

9758

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD Virginia</b> b. COUNTY <b>Prince George?</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>				c. LENGTH OF STAY IN 1b <b>6 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>Key 1801 K Blvd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Mable Mayme</b> Middle <b>Allen</b> Last <b>Allen</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>63</b> yrs.	
9. AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gov. Employee</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>B. B. Nalls</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Infarction</b> <b>332x</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 19</b> , 19 <b>57</b> , to <b>Sept 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept 25</b> , 19 <b>57</b> , and that death occurred at <b>12:00</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George H. McLain</b> M.D.				ADDRESS (Street, city or town, state) <b>1746 K. m. w. - Wash - 6 - D.C.</b>			
PHYSICIAN'S NAME (Type) <b>George H. McLain</b>				DATE SIGNED <b>Dr. George McLain</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/28/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manassas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Manassas Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 27 '57</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

RECEIVED

## 3759 CERTIFICATE OF DEATH

Reg. Dist. No. 242...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince George's</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>	STATE <i>Lo. e</i> COUNTY <i>✓</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>
TOWN <i>Chesley</i>	LENGTH OF STAY (in this place) <i>1 mo.</i>	OR TOWN <i>Washington</i>	STREET ADDRESS (If rural give location) <i>3414 20th St. N.E.</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Nursing Home 2601 Chesley av.</i>	4. DATE (Month) (Day) (Year) OF DEATH: <i>Sept. 4 1957</i>		
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Mary Ann Hufford</i>	9. AGE last birthday <i>87</i> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>Aug 19, 1870</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>housewife retired</i>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Virginia</i>
13. FATHER'S NAME: <i>Hedgman Crouch</i>		14. MOTHER'S MAIDEN NAME: <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT & ADDRESS: <i>William E. Doherty.</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>450.0 Generalized arteriosclerosis</i>			<i>8 yrs.</i>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Fracture hip</i>			<i>6 mos</i>
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8/9</i> , 1957, to <i>9/4</i> , 1957, that I last saw the deceased alive on <i>9/3</i> , 1957, and that death occurred at <i>M</i> , from the causes and on the date stated above.			
SIGNATURE <i>John K. ...</i>		ADDRESS <i>Chesley</i>	DATE SIGNED <i>9/4/57</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>	DATE THEREOF <i>Sept 7, 57</i>	NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>
DATE REC'D BY LOCAL REGISTRAR <i>Sept. 4, 57</i>	REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>	24. FUNERAL DIRECTOR (ADDRESS) <i>W.W. Chambers Co. Washington, D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9/4/57

DR MALONEY - DEP. MED EXAM - CALLED + APPROVED

W.W. Charles Jr  
By W.W. Charles Jr

BUREAU V. 3

SEP 9 1957

RECEIVED



MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

Name of Deceased		Date of Death	
William Henry		D.O.B.	
Place of Birth		Date of Birth	
1906		1906	
Sex		Age	
Male		30	
Race		Color	
White		White	
Marital Status		Cause of Death	
Married		Acute myocardial infarction	
Occupation		Place of Death	
Teacher		Home	
Signature of Physician		Signature of Registrar	
J. H. Smith		J. H. Smith	
Date of Signature		Date of Signature	
1957		1957	

BUREAU V. 1

OCT 1 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09753

9761

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Woodstown</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>67X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>R.F.D. # 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>James T Baylor</b>			4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 4, 1899</b>		9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>County School</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Unknown</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>Unknown</b>			17. INFORMANT <b>Mrs J. I. Baylor, Same as #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia and exhaustion</b> DUE TO (b) <b>Generalized peritonitis</b> DUE TO (c) <b>Rupture of the duodenum</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>car</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of an automobile that was in a collision with another/</b>			
20c. TIME OF INJURY Month, Day, Year <b>7:30 p.m. 9/9/ 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 301</b>	
20f. (City or town) <b>Upper Marlboro P. G.</b>		20g. (County) <b>Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type or print) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>September 11, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (specify) <b>General</b>		22b. DATE THEREOF <b>Sept. 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
22d. LOCATION (City, town, or county) (State) <b>Woodlawn P. G.</b>		22e. ADDRESS <b>1760 V. Ave. DC</b>		22f. REC'D BY REGISTRAR <b>SEP 13 '57</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Distinct Morticians</b>		24b. REGISTRAR'S SIGNATURE <b>John D. Watson</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 13 1957

BUREAU V. S.

Occurrence of an automobile crash was in a collision with another

Route " 301

*James I. Boyd*

James I. Boyd

History of the disease

Generalized parietitis

Tumors and extracranial

History of the disease

Unknown

County School

Virginia

Deceased

November 1, 1951

Bayler

September 11

Woodhouse

2 days

Gravely

Gravely's General Hospital

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09754

9762

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capital Heights</b>	
c. LENGTH OF STAY IN 1b <b>1 day</b>		d. STREET ADDRESS <b>5707 Southern Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rose Mary Beaner</b>		4. DATE OF DEATH <b>September 19 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 18/57</b>
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		12. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
13. BIRTHPLACE (State or foreign country) <b>Virginia</b>		14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. FATHER'S NAME <b>James Beaner</b>		16. MOTHER'S MAIDEN NAME <b>Mary Helen ?</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>none</b>	
19. INFORMANT <b>Mary Helen Beaner</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO (b) <b>Overlaying of mother</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>9240</b> DUE TO (c) <b>Overlaying of mother in bed at home</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>9240</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Overlaying of mother in bed at home</b>	
20c. TIME OF INJURY Month, Day, Year <b>9/ 19 19 57</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Capital Heights</b> (County) <b>P. G.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9/19/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-21-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington</b> (State) <b>D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines &amp; Co.</b>		24a. REC'D BY REGISTRAR <b>901 3rd St., S. W.</b>	
DATE <b>SEP 23 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	



Prince George's  
Overly  
Prince George's General Hospital  
200 Southern Avenue  
Baltimore, Maryland  
September 18, 1957  
U.S.A.  
James Bennett  
Mary Helen Bennett  
Asphyxia  
Overlaying of mother

RECEIVED  
SEP 23 1957  
BUREAU V. H.

James I. Boyd  
1-1-57  
1-1-57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09755

9763

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James John Berbig</b>		4. DATE OF DEATH Month <b>September</b> Day <b>2</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-16-90</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholson Berbig</b>		14. MOTHER'S MAIDEN NAME <b>M. Linda Rutherford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dorothy May Berbig; same address.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>September 2, 1957</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/5/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 9 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Paul</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP-9-1957

BUREAU V. S.

acute congestive heart failure  
cardiovascular renal disease

Nicholas George

Freeman  
wife  
John  
James

Prince Georges General Hospital

Cherry  
D.A.

Prince Georges

STATE  
DEPT.

9829

CERTIFICATE OF DEATH

09756

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland, Maryland.</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4720- Hudson Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Oxon Hill, Maryland</b>	
f. STREET ADDRESS <b>2283 - Owens Road S. E.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>B.</b> Last <b>BIVENS</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>22nd.</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 11- 1884</b>
9. AGE (In years lost birthday) yrs. <b>73</b>		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Oxon Hill, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Dean</b>		14. MOTHER'S MAIDEN NAME <b>Betty Owens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mildred E. DeMar, 4720- Hudson Ave., S.E.</b>	
17. INFORMANT <b>Mildred E. DeMar, 4720- Hudson Ave., S.E.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 21, 19 57</b> to <b>Sept 22, 19 57</b> , that I last saw the deceased alive on <b>Sept 21, 19 57</b> , and that death occurred at <b>11:58 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. Schwartzman</b> M.D.		DATE SIGNED <b>2007 Nichols Ave St Wash 20, D.C.</b>	
PHYSICIAN'S NAME (Type) <b>A. SCHWARTZMAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 25th 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Oxon Hill, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Brothers</b>		24a. REC'D BY REGISTRAR <b>SEP 24 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 24 1957

BUREAU V. S.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD		CERTIFICATE OF DEATH	
Name of Deceased		Sex	
Date of Birth		Date of Death	
Place of Birth		Place of Death	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Date of Registration	



CERTIFICATE OF DEATH

09757

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Berwyn Heights, Maryland.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>8922 57th avenue,.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOEL</b> Middle <b>HOFFMAN</b> Last <b>BLACK</b>		4. DATE OF DEATH Month <b>September</b> Day <b>28</b> , Year <b>19 57-</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/1887 1888</b>
9. AGE (In years last birthday) <b>70 69 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Engineer</b>	
11. BIRTHPLACE (State or foreign country) <b>Huntingdon, Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Jacob Black</b>		14. MOTHER'S MAIDEN NAME <b>Emma Fryling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Amratha Manning Camp Hill, Penna.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>420.0</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>AND PREVIOUS MYOCARDIAL INFARCTION</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JULY</b> 19 <b>57</b> , to <b>SEPT 24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>24 SEPT</b> , 19 <b>57</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1726 EYE ST. N.W. WASH D.C.</b> DATE SIGNED <b>6 D.C.</b> ACTUAL SIGNATURE <b>Leslie H. French</b> M.D. <b>1726 EYE ST. N.W. WASH D.C.</b> PHYSICIAN'S NAME (Type) <b>Leslie H. French</b> <b>1726 Eye St N. W. Washington D. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/1/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Huntingdon Penna</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 1 '57</b>	24b. REGISTRAR'S SIGNATURE <b>Quelch</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

9830

## CERTIFICATE OF DEATH

09758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Texas b. COUNTY Val Verde			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB, Wash. 25, D.C.				c. LENGTH OF STAY IN 1b See Reverse			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Andrews AFB, Wash. 25, D.C.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John Edward Boland				4. DATE OF DEATH Month Day Year September 12 1957			
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 May 1922	9. AGE (In years lost birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot, U.S. Air Force		10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force		11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Deceased - Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II 348-12-4210		17. INFORMANT Address 4080th Air Base Group M/Sgt Paul Lock, Laughlin AFB, Texas			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries, multiple, severe, extreme 860x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aircraft Accident DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft Crash, Full Particulars Unknown			
20c. TIME OF INJURY Hour a.m. Month, Day, Year 0225 PM Sept 12 1957				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Andrews AFB	
				20f. (City or town) Andrews AFB, Prince Georges, Md.		(County) (State)	
21. I certify that I attended the deceased from See Reverse 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 0225 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Reginald P. McManus				M.D. 1401st USAF Hospital 12 September 1957 Andrews Air Force Base			
PHYSICIAN'S NAME (Type) REGINALD P. MCMANUS CAPT USAF (MC)				Washington 25, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517-11th St. S.E.				ADDRESS 517-11th St. S.E.		24a. REC'D BY REGISTRAR DATE SEP 17 '57	
				24b. REGISTRAR'S SIGNATURE W.W. Chambers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A corrected Certificate of Death will be prepared and forwarded if additional information is received concerning itmes presently indicated as unknown.

CERTIFICATE

I, the undersigned, while in performance of duties as Medical Officer of the Day, for the 1401st USAF Hospital, do hereby certify that I was summoned to the scene of the aircraft accident and found subject officer dead upon my arrival thereat. It is my opinion that death occurred approximately 10 to 15 minutes prior to my arrival.

Item 1c: Unable to determine, aircraft had not landed.

*Reginald P. McManus*  
REGINALD P. MCMANUS  
CAPT, USAF (MC)  
Attending Physician

RECEIVED  
SEP 18 1957  
BUREAU V. 3

## 9765 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09759

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beaver Heights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>1702 Kenilworth Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Regina Leigh Boston</b>		4. DATE OF DEATH <b>Sept. 20, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1957</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR <b>51</b> Months	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard M. Boston</b>		14. MOTHER'S MAIDEN NAME <b>Jo-ann Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Jo-ann Boston; same address</b>	
17. INFORMANT <b>Jo-ann Boston; same address</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>491X</b> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Sept. 21, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-24-57</b>		22b. DATE THEREOF <b>Harmony Co. Wash. D.C.</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wash. D.C.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Ernest</b>		24a. RESEBY REGISTRAR <b>SEP 20 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Ernest</b>		24c. REGISTRAR'S SIGNATURE	



FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

SEP 26 1957

RECEIVED

9766

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b>				c. LENGTH OF STAY IN 1b <b>7 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>W</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-6-86</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Brown</b>				14. MOTHER'S MAIDEN NAME <b>Maggie Burley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>William P. Brown</b>		Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unreined</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Glomerular Nephritis 1 month</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 17</b> , 19 <b>57</b> , to <b>Sept 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept 18</b> , 19 <b>57</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4300 Raymond Drive</b> DATE SIGNED <b>9/19/57</b> ACTUAL SIGNATURE <b>Samuel J. Sugar M.D.</b> PHYSICIAN'S NAME (Type) <b>Samuel J. Sugar M.D.</b> <b>MT RAINIER, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Buried</b>		<b>9-21-57</b>		<b>Mt. View</b>		<b>Mitchellsville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Beese, Jr.</b>				ADDRESS <b>Arpa, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 24 '57</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Houch</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2160

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to fading and bleed-through.

BUREAU V. S.

SEP 24 1957

RECEIVED

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9767

# CERTIFICATE OF DEATH

09761

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md.		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN 1b 1Hr. & 1/2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 207 65th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Baby Girl		Middle Bullard		Last	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 3 1957	
				9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Kenneth Lee Bullard		14. MOTHER'S MAIDEN NAME Betty Delores Kline					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Betty Bullard Mother		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Atelectasis Prematurity	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 3, 1957, to Sept 4, 1957, that I last saw the deceased alive on Sept 4, 1957, and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) John W. Perkins, 5301 Hawthorne St., Hyattsville, Md. DATE SIGNED 9/4/57							
ACTUAL SIGNATURE John W. Perkins		PHYSICIAN'S NAME (Type) John W. Perkins					
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF Sept 1957		22c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery		22d. LOCATION (City, town, or county) Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Perkins		ADDRESS Arlington		24a. REC'D BY REGISTRAR DATE SEP 18 1957		24b. REGISTRAR'S SIGNATURE Deborah	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

$$1000 / 254 \times \sqrt{3}$$

BUREAU V. 3

SEP 18 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9747  
CERTIFICATE OF DEATH

09762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pa. George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>P. I.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda City, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>		d. STREET ADDRESS <u>3807 Parkwood Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Virginia</u> Last <u>BURTON</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES TAYMAN</u>		14. MOTHER'S MAIDEN NAME <u>JEANIE F. TAYMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Sam. Tayman</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>57</u> , and that death occurred at <u>1:00</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Trozzo, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>1840 Michigan Ave NE Washington, DC</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-23-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>See Funeral Home Wash DC</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>SEP 23 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapel Oaks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>1310 57th Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>Butler</b> Last <b>Butler</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 Mar. 1902</b>
9. AGE (In years last birthday) yrs. <b>55</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>28</b> Hours <b>19</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Greenwood, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wister Hughey</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured aneurysm of Circle of Willis</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>6 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>SEP 28, 1957</b> to <b>SEP 28, 1957</b> , that I last saw the deceased alive on <b>SEP 28, 1957</b> , and that death occurred at <b>2:25A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel J. Sugar</b> M.D.		ADDRESS (Street, city or town, state) <b>MT RAINIER, Md</b> DATE SIGNED <b>9/28/57</b>	
PHYSICIAN'S NAME (Type) <b>SAMUEL W. N. SUGAR M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>10/1/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Sm</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph Barbour</b> ADDRESS <b>48-K St. N.E.</b>		24a. REC'D BY REGISTRAR DATE <b>9/28/57</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>



9769

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b>		4. DATE OF DEATH Month <b>4</b> Day <b>Sept.</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Aug 1957</b>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>8</b> Hours <b>Min.</b>	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edward Jackson Cain</b>		14. MOTHER'S MAIDEN NAME <b>Anna Fargason</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>mother</b>		Address <b>as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 30, 1957</b> , to <b>Sept 4, 1957</b> , that I last saw the deceased alive on <b>Sept - 4, 1957</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton St, Hyattsville</b>	
PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>		DATE SIGNED <b>9/4/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/9/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gaschs Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

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Outcast

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09765

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, give nearest town) <u>Southland</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Southland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3010 Parkway Terrace Drive</u>			d. STREET ADDRESS <u>3010 Parkway Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Claire</u> Last <u>Casey</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3, 1904</u>		9. AGE (in years last birthday) <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
13. FATHER'S NAME <u>Hugh Casey</u>		14. MOTHER'S MAIDEN NAME <u>Rechel Navy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>39-100000000</u>		17. INFORMANT <u>John H. Casey</u> Address <u>39 Monticello Rd Alexandria Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>James I Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JAMES I BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>		22e. (State) <u>D.C.</u>		22f. (City, town, or county) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>		ADDRESS <u>317 Pa. Ave., SE DC3</u>		24a. REC'D BY REGISTRAR <u>Sept 30, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>		DATE <u>Sept 30, 1957</u>		24c. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

ET.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
JRS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is mostly blank with some faint, illegible markings.

BUREAU V. 51

OCT 2 1957

RECEIVED

9770

CERTIFICATE OF DEATH

09766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>15 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. STREET ADDRESS <b>2627 Nicholson St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Chandler</b> Last <b>Chandler</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>3</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 May 1922</b>	
9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.		IF UNDER 24 HRS. Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Montana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>David Flansburg</b>				14. MOTHER'S MAIDEN NAME <b>Josephine ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Arlie V. Chandler</b> Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive B. I. Hemorrhage</b> 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>multiple ulceration 1st pnt. duodenum</b> DUE TO (c) <b>Acute pancreatic necrosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>8-19</b> , 19 <b>57</b> , to <b>9-3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-2</b> , 19 <b>57</b> , and that death occurred at <b>4:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5432 QUEENS CHAPEL RD</b> DATE SIGNED <b>9/3/57</b>							
ACTUAL SIGNATURE <b>Ronald S Fleischer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>RONALD S FLEISCHER</b>				<b>HYATTSTVILLE, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 6, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 9 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Quelch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 9 1957

BUREAU V. S.

STATE OF TEXAS		COUNTY OF DALLAS	
DECEASED		JAMES EARL RAY	
DATE OF DEATH		JUNE 15 1957	
PLACE OF DEATH		JAIL	
AGE		35	
SEX		MALE	
RACE		WHITE	
MARRIAGE		MARRIED	
WIFE		JANE E. RAY	
BIRTH		JAN 15 1922	
PLACE OF BIRTH		MOBILE, ALABAMA	
EDUCATION		HIGH SCHOOL	
OCCUPATION		CONSPIRACY	
CAUSE OF DEATH		HOMICIDE	
MANNER OF DEATH		SUICIDE	
FINDINGS		...	
TESTIMONY		...	
SIGNATURE		...	
DATE		...	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1957



9771

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				e. STREET ADDRESS <b>1 RTE. # 2 - BOX 90</b>			
3. NAME OF DECEASED (Type or print) First <b>NICEY</b> Middle <b>ANN</b> Last <b>CLARK</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1875</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Granville Pingleton</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Jane Austin</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>same as above</b>				17. INFORMANT <b>John B. Pingleton-</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154X</b> DUE TO <b>Heart &amp; pulmonary embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Rectum</b> (c) <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 48 hrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>9/28</b> , 19 <b>57</b> , to <b>9/30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/30</b> , 19 <b>57</b> , and that death occurred at <b>9/30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. B. Sasscer</b>				ADDRESS (Street, city or town, state) <b>Upper Marlboro, Maryland.</b> DATE SIGNED <b>9/30/57.</b>			
PHYSICIAN'S NAME (Type) <b>R. B. Sasscer, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Oak Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mitchellville Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>				42a. REC'D BY REGISTRAR <b>OCT 9 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Overland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V.

1957 6 100

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9751**  
**CERTIFICATE OF DEATH**

09767

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUATTSVILLE</u>				c. LENGTH OF STAY IN lb <u>15</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PAINT BRANCH Nursing Home</u> <u>3130 Powder Mill Road</u>				d. STREET ADDRESS <u>6708-44th AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LUKE</u> Middle <u>A</u> Last <u>COLE</u>				4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 24, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>							
13. FATHER'S NAME <u>ARIOS Nye Cole</u>				14. MOTHER'S MAIDEN NAME <u>ZIDENA KELLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>S. Elizabeth Cole</u> Address <u>6708-44th Ave Huattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerular nephritis</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> to <u>Sept 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June</u> , 19 <u>57</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.C. Weintraub</u> M.D.				ADDRESS (Street, city or town, state) <u>30 C Ridge Rd, Greentree, Pa</u>			
DATE SIGNED <u>9/2/57</u>							
PHYSICIAN'S NAME (Type) <u>W.C. Weintraub</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co.-2901 14th St., N.W. DC</u>				ADDRESS <u>Wash.</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Leary</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. PLACE OF DEATH                  [Faint text]</p>	
<p>7. OCCUPATION                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. MANNER OF DEATH                  [Faint text]</p>		<p>10. TIME OF DEATH                  [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Faint text]</p>	
<p>13. DATE OF DEATH                  [Faint text]</p>		<p>14. TIME OF DEATH                  [Faint text]</p>	
<p>15. PLACE OF DEATH                  [Faint text]</p>		<p>16. PLACE OF DEATH                  [Faint text]</p>	
<p>17. PLACE OF DEATH                  [Faint text]</p>		<p>18. PLACE OF DEATH                  [Faint text]</p>	
<p>19. PLACE OF DEATH                  [Faint text]</p>		<p>20. PLACE OF DEATH                  [Faint text]</p>	
<p>21. PLACE OF DEATH                  [Faint text]</p>		<p>22. PLACE OF DEATH                  [Faint text]</p>	
<p>23. PLACE OF DEATH                  [Faint text]</p>		<p>24. PLACE OF DEATH                  [Faint text]</p>	
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<p>29. PLACE OF DEATH                  [Faint text]</p>		<p>30. PLACE OF DEATH                  [Faint text]</p>	
<p>31. PLACE OF DEATH                  [Faint text]</p>		<p>32. PLACE OF DEATH                  [Faint text]</p>	
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<p>39. PLACE OF DEATH                  [Faint text]</p>		<p>40. PLACE OF DEATH                  [Faint text]</p>	
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<p>65. PLACE OF DEATH                  [Faint text]</p>		<p>66. PLACE OF DEATH                  [Faint text]</p>	
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<p>69. PLACE OF DEATH                  [Faint text]</p>		<p>70. PLACE OF DEATH                  [Faint text]</p>	
<p>71. PLACE OF DEATH                  [Faint text]</p>		<p>72. PLACE OF DEATH                  [Faint text]</p>	
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<p>77. PLACE OF DEATH                  [Faint text]</p>		<p>78. PLACE OF DEATH                  [Faint text]</p>	
<p>79. PLACE OF DEATH                  [Faint text]</p>		<p>80. PLACE OF DEATH                  [Faint text]</p>	
<p>81. PLACE OF DEATH                  [Faint text]</p>		<p>82. PLACE OF DEATH                  [Faint text]</p>	
<p>83. PLACE OF DEATH                  [Faint text]</p>		<p>84. PLACE OF DEATH                  [Faint text]</p>	
<p>85. PLACE OF DEATH                  [Faint text]</p>		<p>86. PLACE OF DEATH                  [Faint text]</p>	
<p>87. PLACE OF DEATH                  [Faint text]</p>		<p>88. PLACE OF DEATH                  [Faint text]</p>	
<p>89. PLACE OF DEATH                  [Faint text]</p>		<p>90. PLACE OF DEATH                  [Faint text]</p>	
<p>91. PLACE OF DEATH                  [Faint text]</p>		<p>92. PLACE OF DEATH                  [Faint text]</p>	
<p>93. PLACE OF DEATH                  [Faint text]</p>		<p>94. PLACE OF DEATH                  [Faint text]</p>	
<p>95. PLACE OF DEATH                  [Faint text]</p>		<p>96. PLACE OF DEATH                  [Faint text]</p>	
<p>97. PLACE OF DEATH                  [Faint text]</p>		<p>98. PLACE OF DEATH                  [Faint text]</p>	
<p>99. PLACE OF DEATH                  [Faint text]</p>		<p>100. PLACE OF DEATH                  [Faint text]</p>	

BUREAU V. S.

SEP 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9832

CERTIFICATE OF DEATH

09768

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D. C.</b> b. COUNTY <b>-</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47x-3		
c. LENGTH OF STAY IN 1b <b>2 yrs., 1 mo., 30 days.</b>			d. STREET ADDRESS <b>1628 27th St., S. E.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>P.</b> Last <b>Conner</b>			4. DATE OF DEATH Month <b>9</b> Day <b>12</b> Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/5/1897</b>		9. AGE (In years last birthday) <b>60</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James D. Conner</b>			14. MOTHER'S MAIDEN NAME <b>Mary Lane</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-03-4166</b>	17. INFORMANT <b>Decedent</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Pulmonary emphysema</b> DUE TO (c) <b>Pulmonary tuberculosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.,</b> <b>5 yrs.,</b> <b>10 yrs.,</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/13</b> , 19 <b>55</b> , to <b>9/12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/12</b> , 19 <b>57</b> , and that death occurred at <b>11:30PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Glenn Dale Hospital</b> <b>9/12/57</b>					
ACTUAL SIGNATURE <b>Moe Weiss</b>		M.D. <b>Glenn Dale Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		<b>Glenn Dale, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>9-16-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery Wash</b>		22d. LOCATION (City, town, or county) (State) <b>D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan Inc. #222</b>		ADDRESS <b>317 Penn Ave</b>		24a. REC'D BY REGISTRAR <b>SEP 17 '57</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>



CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
1957-09-17		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

RECEIVED

SEP 17 1957

BUREAU V. S.

9833

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base				c. LENGTH OF STAY IN 1b Unknown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1401ST USAF Hospital (MATS)				d. STREET ADDRESS #6, N. Street S.W. 47x-3			
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Cousar				4. DATE OF DEATH Month September Day 1 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 April 1896	9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rayford, N.C.		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME James Cousar				14. MOTHER'S MAIDEN NAME Ida Hodges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clara Cousar #6, N. Street S.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33/x Cerebral Hemorrhage DUE TO (b) Arteriolar Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6 Hours 3 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 September, 1957, to 1 September, 1957, that I last saw the deceased alive on 1 September, 1957, and that death occurred at 1:38 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles L. Picus				M.D. 1401ST USAF Hospital (MATS)			
PHYSICIAN'S NAME (Type) CHARLES L. PICUS CAPT., USAF (MC) Andrews Air Force Base, Washington 25, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-6-57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Mem.		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED <b>JOHN J. ROSS</b>		2. SEX <b>MALE</b>		3. RACE <b>WHITE</b>		4. DATE OF BIRTH <b>1910</b>		5. PLACE OF BIRTH <b>NEW YORK</b>	
6. CITY OF DEATH <b>BALTIMORE</b>		7. COUNTY OF DEATH <b>JOHNS HOPKINS</b>		8. STATE OF DEATH <b>MARYLAND</b>		9. DATE OF DEATH <b>1957</b>		10. PLACE OF DEATH <b>HOME</b>	
11. CAUSE OF DEATH <b>HEART DISEASE</b>		12. MANNER OF DEATH <b>NATURAL</b>		13. ICD-9 CODE <b>410</b>		14. ICD-10 CODE <b>I20</b>		15. OTHER CAUSE OF DEATH <b>NO</b>	
16. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		17. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		18. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		19. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		20. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
21. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		22. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		23. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		24. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		25. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
26. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		27. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		28. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		29. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		30. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
31. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		32. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		33. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		34. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		35. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
36. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		37. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		38. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		39. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		40. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
41. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		42. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		43. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		44. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		45. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
46. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		47. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		48. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		49. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		50. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
51. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		52. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		53. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		54. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		55. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
56. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		57. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		58. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		59. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		60. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
61. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		62. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		63. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		64. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		65. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
66. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		67. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		68. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		69. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		70. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
71. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		72. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		73. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		74. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		75. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
76. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		77. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		78. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		79. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		80. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
81. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		82. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		83. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		84. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		85. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
86. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		87. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		88. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		89. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		90. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
91. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		92. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		93. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		94. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		95. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	
96. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		97. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		98. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>		99. SIGNATURE OF WITNESS <b>JOHN J. ROSS</b>		100. SIGNATURE OF DECEASED <b>JOHN J. ROSS</b>	

BUREAU V. 8

SEP 4 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

097770

Reg. Dist. No. 231

9772

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>2008 R Street N. W.</b>	
3. NAME OF DECEASED (Type or print) <b>William Edward Crump</b>		4. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 2, 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Clerk</b>	
13. BIRTHPLACE (State or foreign country) <b>Virginia</b>		14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. FATHER'S NAME <b>William F. Crump</b>		16. MOTHER'S MAIDEN NAME <b>Elizabeth Reynolds</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		18. SOCIAL SECURITY NO. <b>W.W. 1</b>	
19. INFORMANT <b>Eligabeth Butler, 7330 12th N. W.</b>		Address <b>Washington, D.C.</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular renal disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>September 15, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/18/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Sawler's Sons</b>		24a. REC'D BY REGISTRAR <b>SEP 20 57</b>	
ADDRESS <b>1756 Pennsylvania Ave NW, Washington, DC</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Place of Death: Prince George's  
County: Prince George's  
City: Washington

Sex: Male  
Race: White  
Age: 3 days

Place of Birth: Prince George's General Hospital  
Date of Birth: 3008 N Street N. W.

Occupation: William Howard  
Date of Death: 18 September 1957

Marital Status: Single  
Date of Marriage: 29

Place of Residence: Prince George's  
County: Prince George's

Place of Death: Prince George's  
County: Prince George's

Place of Death: Prince George's  
County: Prince George's

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County: Prince George's

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County: Prince George's

Place of Death: Prince George's  
County: Prince George's

RECEIVED  
SEP 20 1957  
BUREAU V. S.





# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

See D-12 10

Name of Deceased		Date of Death	
John Doe		1957	
Age		Sex	
65		Male	
Place of Birth		Cause of Death	
New York		Heart Disease	
Date of Birth		Place of Death	
1957		Home	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. S.

SEP 16 1957

RECEIVED

DO NOT WRITE IN THESE SPACES

9774

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COTTAGE CITY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>3704 - 37th. AVE.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>DEANE</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>24</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 21, 1895</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Julian W. Deane</b>				14. MOTHER'S MAIDEN NAME <b>Ella Riehl</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>578 10 5762</b>		17. INFORMANT <b>Vivian M Deane</b>		Address <b>Cottage City Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Arteriosclerosis of Heart</b> <b>592X</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9/24</b> , 19 <b>57</b> , to <b>9/24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/24</b> , 19 <b>57</b> , and that death occurred at <b>8:45 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A Deitz</b>				DATE SIGNED <b>9-24-57</b>			
PHYSICIAN'S NAME (Type) <b>A Deitz</b>				ADDRESS (Street, city or town, state) <b>Hyattsville Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>			
24a. SIGNED BY REGISTRAR <b>F. Gasch's Sons</b>				24b. REGISTRAR'S SIGNATURE <b>F. Gasch's Sons</b>			
DATE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX M		RACE W		DATE OF BIRTH JAN. 15, 1903		PLACE OF BIRTH BALTIMORE, MD.	
RESIDENCE 1234 E. BALTIMORE ST.		OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH SEP. 26, 1957		PLACE OF DEATH HOSPITAL	
FATHER'S NAME JAMES H. HARRIS		MOTHER'S NAME MARY J. HARRIS		EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARITAL STATUS MARRIED		SIGNED BY JAMES H. HARRIS	
DATE OF DEATH SEP. 26, 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		SIGNED BY JAMES H. HARRIS	
FATHER'S NAME JAMES H. HARRIS		MOTHER'S NAME MARY J. HARRIS		EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARITAL STATUS MARRIED		SIGNED BY JAMES H. HARRIS	
DATE OF DEATH SEP. 26, 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		SIGNED BY JAMES H. HARRIS	

BUREAU V. 2

SEP 26 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9775

CERTIFICATE OF DEATH

Reg. Dis. No.

09773

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4405-40th Street				d. STREET ADDRESS 4405-40th Street			
3. NAME OF DECEASED (Type or print) Maurice C. Dent				4. DATE OF DEATH Sept. 14 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/90	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chessman				10b. KIND OF BUSINESS OR INDUSTRY Darby Co. Washington DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin A. Dent				14. MOTHER'S MAIDEN NAME Roberta E. Calvert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-01285		17. INFORMANT Address Malcolm A. Dent, Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X Carcinoma Esophagus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 1, 1956, to Sept. 14, 1957, that I last saw the deceased alive on Sept. 14, 1957, and that death occurred at 3 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE R. S. Williams, M.D.				ADDRESS (Street, city or town, state) 35 New York Ave. Wash, D.C.			
PHYSICIAN'S NAME (Type) R. S. WILLIAMS				DATE SIGNED 9/14/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Mt. Rainier, Inc.				ADDRESS 24a. REC'D BY REGISTRAR DATE SEP 18 '57		24b. REGISTRAR'S SIGNATURE	



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF BIRTH [Faint text, possibly "1912"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]		OCCUPATION [Faint text, possibly "Teacher"]	
DATE OF DEATH [Faint text, possibly "Sep 15 1957"]		PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		MEDICAL ATTENDANCE [Faint text, possibly "Physician"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF JURY [Faint signature]		SIGNATURE OF JUDGE [Faint signature]	

**RECEIVED**  
 SEP 18 1957  
 BUREAU V. 3

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

097774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Foote		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Patonae River		d. STREET ADDRESS 329-11 <sup>th</sup> Street SW	
3. NAME OF DECEASED (Type or print) Robert Thomas Dickerson		4. DATE OF DEATH Month Sept Day 28 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 27, 1901
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deck Hand Shipping		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Benjamin Alexander Dickerson	
14. MOTHER'S MAIDEN NAME Esther Tolmadge		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Berrie Carter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 851X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Drowning DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from a tugboat into river		20c. TIME OF INJURY Month, Day, Year 2:30 a.m. 9-25-57	
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) River	
20f. (City or town) Near Alexandria		(County) Va	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Sept 28, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		24a. REC'D BY REGISTRAR	
ADDRESS 517 11 <sup>th</sup> St SE		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 4 1957

RECEIVED

## 97778 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

097775

Reg. Dist. No. 231

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

D.O.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

XO Glen Arden

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

d. STREET ADDRESS

7th and Lincoln Avenue

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☐3. NAME OF DECEASED  
(Type or print)

Le Roy

Dock

## 4. DATE OF DEATH

September

29

19 57

## 5. SEX

Male

## 6. COLOR OR RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## 8. DATE OF BIRTH

March 2, 1908

## 9. AGE (In years last birthday)

49 yrs.

## IF UNDER 1 YEAR

Months

## IF UNDER 24 HRS.

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Janitor

## 10b. KIND OF BUSINESS OR INDUSTRY

High School

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Andrew Dock

## 14. MOTHER'S MAIDEN NAME

Lena Butler

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

## Address

Gladys Dock; same address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute congestive heart failure

442X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

Cardiovascular renal disease

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

## 20c. TIME OF INJURY

Month, Day, Year

Hour o. m. p. m.

19

## 20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

## ACTUAL SIGNATURE

John T. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

September 29, 1957

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

Oct. 3, 1957

## 22c. NAME OF CEMETERY OR CREMATORY

Evergreen

## 22d. LOCATION (City, town, or county)

Bladensburg Md.

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Lunny Washington &amp; Son 467 N. of. N.W. DC

## ADDRESS

## 24a. REC'D BY REGISTRAR

OCT 3 '57

## 24b. REGISTRAR'S SIGNATURE

A. J. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF  
HEALTH DEPT

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING OR  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE OF EXAMINATION: [illegible]

RECEIVED

RECEIVED  
OCT 3 1957  
BUREAU V. S.



9777

Items 7, 10a, 11, 12, 13, 14, Film G220 9-24-57 et

CERTIFICATE OF DEATH

097776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>24 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>5103 Navahoe St.,</b>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Douglas</b> Last <b>Douglas</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-08</b>	9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pastry Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Rockhill, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Epherfon Douglas</b>				14. MOTHER'S MAIDEN NAME <b>Georgianne Douglas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Masseri. pul. embolism</b> <b>610X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Benzin prostate hyperplasia</b> DUE TO (c) <b>c prostatectomy</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>8/23, 1957</b> , to <b>9/15, 1957</b> , that I last saw the deceased alive on <b>9-15, 1957</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel J. N. Sugar</b> M.D.				ADDRESS (Street, city or town, state) <b>4300 KAYWOOD DR 9-16-57</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b>				MT RAINIER, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Benning Rd SE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John &amp; Jenkins</b>				ADDRESS <b>4804 Ex Ave</b>		24a. REC'D BY REGISTRAR <b>DATE 19 57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Deitch</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
FILING		INDEXING	
RECEIVED		FILED	

BUREAU V. 8

SEP 19 1957

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN PERMISSION OF THE DEPARTMENT OF HEALTH. IT IS THE POLICY OF THE DEPARTMENT TO MAKE THIS RECORD AVAILABLE TO THE PUBLIC FOR RESEARCH AND STATISTICAL PURPOSES. IT IS REQUESTED THAT YOU KEEP THIS RECORD IN A SAFE PLACE AND NOT TO DESTROY IT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09777

9835

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>		d. STREET ADDRESS <u>210 C St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edmund R. Downey</u>		4. DATE OF DEATH Month Day Year <u>Sept. 1 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11/14/1889</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News Vendor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Downey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>deceased</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cor pulmonale; Cirrhosis of the Liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 8</u> , 19 <u>54</u> , to <u>Sept. 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 1</u> , 19 <u>57</u> , and that death occurred at <u>6:15A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Moe Weiss</u> M.D.		Glenn Dale Hospital, Glenn Dale 9/1/57	
PHYSICIAN'S NAME (Type) <u>Moe Weiss M.D.</u>		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wash. Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Wash. D.C.</u>	
ADDRESS <u>741-11th St. N.E.</u>		24b. REGISTRAR'S SIGNATURE <u>Wash. D.C.</u>	

RECEIVED

## CERTIFICATE OF DEATH

09778

Reg. Dist. No.

9778

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Mass</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlemont</u> 58X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>-</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Alfred</u> Last <u>Dunlop</u>		4. DATE OF DEATH 9 Month <u>2</u> Day Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1935</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technical Illustrator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bayshore, L.I.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leslie R. Dunlop</u>		14. MOTHER'S MAIDEN NAME <u>Marion E. Dickover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs. Marion Dunlop-Charlemont, Mass.</u>	
17. INFORMANT Address <u>Mrs. Marion Dunlop-Charlemont, Mass.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>leukemia and virus</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>leukemia metastasis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1-</u> , 19 <u>57</u> , to <u>9-2-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-2-</u> , 19 <u>57</u> , and that death occurred at <u>8:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert Dunlop</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>transportation</u>		22b. DATE THEREOF <u>9/3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenfield</u>		22d. LOCATION (City, town, or county) (State) <u>Massachusetts</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU N. 3

SEP 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9779

CERTIFICATE OF DEATH

09779

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>23 Greenbelt</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>10 S Plateau Pl.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louise</b>		First <b>M</b> Middle <b>Eastman</b> Last		4. DATE OF DEATH <b>Sept.</b>		Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6 Sept 1882</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>S.S. Penney</b>				14. MOTHER'S MAIDEN NAME <b>Unk/</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ruth Mac Kenzie</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction occipital lobe</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Both Cerebral Hemispheres</b> DUE TO (c) <b>Hyper-tension arterio-sclerotic kidneys</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-28-57</b> to <b>9/3-1957</b> , that I last saw the deceased alive on <b>9/3-1957</b> , and that death occurred at <b>6, 12A M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>T. L. Bergman</b>				ADDRESS (Street, city or town, state) <b>Hyattsville, Md.</b>		DATE SIGNED <b>SEP 3, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Til Bergman</b>				Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Leete Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Guilford, Conn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. RECEIVED BY REGISTER <b>SEP 5 1957</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. T. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 624

<p>1. Name of deceased                  Grace's Son</p>		<p>2. Sex                  Male</p>		<p>3. Age                  6 days</p>		<p>4. Date of birth                  10 8 1957</p>		<p>5. Place of birth                  Baltimore</p>	
<p>6. Name of mother                  Grace's Son</p>		<p>7. Name of father                  Grace's Son</p>		<p>8. Date of death                  10 8 1957</p>		<p>9. Place of death                  Baltimore</p>		<p>10. Cause of death                  (To be filled in by physician)</p>	
<p>11. Name of physician                  (To be filled in by physician)</p>		<p>12. Name of attending physician                  (To be filled in by physician)</p>		<p>13. Name of funeral home                  (To be filled in by funeral home)</p>		<p>14. Name of cemetery                  (To be filled in by funeral home)</p>		<p>15. Name of registrar                  (To be filled in by registrar)</p>	
<p>16. Name of informant                  (To be filled in by informant)</p>		<p>17. Name of informant                  (To be filled in by informant)</p>		<p>18. Name of informant                  (To be filled in by informant)</p>		<p>19. Name of informant                  (To be filled in by informant)</p>		<p>20. Name of informant                  (To be filled in by informant)</p>	

BUREAU V. 2

SEP 5 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9748

## CERTIFICATE OF DEATH

Reg. Dist. No. **097806**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> c. LENGTH OF STAY IN 1b <u>4 wks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Saint Branch Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1923 Jackson St., N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Wilmer Adam Eisenhower</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>Sept. 17 1957</u> Month Day Year			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 11, 1888</u> Months Days Hours Min.	
<b>9. AGE</b> (In years last birthday) <u>69</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Accountant</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>York Co., Penn.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Peter Eisenhower</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Jean Neuffman</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Nursing home records.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombotic (cold)</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I attended the deceased from</b> <u>Aug 23, 1957</u> , to <u>Sept 17, 1957</u> , that I last saw the deceased alive on <u>Sept 10, 1957</u> , and that death occurred at <u>1:58</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2701 Cornell Ave N.W. Takoma Park, D.C.</u> DATE SIGNED <u>9-17-57</u> ACTUAL SIGNATURE <u>James H. Hines</u> M.D. PHYSICIAN'S NAME (Type) <u>The S.H. Hines Company, 2901 14th St. N.W. Washington, D.C.</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>removal</u>		<b>22b. DATE THEREOF</b> <u>9/19/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Prospect Hill Cemetery York, Pa.</u>		<b>22d. LOCATION</b> (City, town, or county) (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Company, 2901 14th St. N.W. Washington, D.C.</u>				<b>24. REGISTRAR'S SIGNATURE</b> <u>a. W. Hedrich</u> DATE <u>9-17-57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9732

<p>1. NAME OF DECEASED <i>BURKAV Y. S.</i></p>		<p>2. SEX <i>M</i></p>	
<p>3. AGE <i>38</i></p>		<p>4. DATE OF BIRTH <i>SEP 20 1919</i></p>	
<p>5. PLACE OF BIRTH <i>RUSSIA</i></p>		<p>6. OCCUPATION <i>LABORER</i></p>	
<p>7. MARITAL STATUS <i>MARRIED</i></p>		<p>8. DATE OF MARRIAGE <i>MAY 1945</i></p>	
<p>9. NAME OF WIFE <i>IRINA BURKAV</i></p>		<p>10. NAME OF CHILDREN <i>YOUNG</i></p>	
<p>11. CAUSE OF DEATH <i>HEART DISEASE</i></p>		<p>12. PLACE OF DEATH <i>HOSPITAL</i></p>	
<p>13. DATE OF DEATH <i>SEP 20 1957</i></p>		<p>14. TIME OF DEATH <i>10:00 AM</i></p>	
<p>15. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>		<p>16. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>	

BURKAV Y. S.

SEP 20 1957

RECEIVED



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9752

## CERTIFICATE OF DEATH

097845

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>same</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	c. LENGTH OF STAY IN 1b <i>16 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>same</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>400 Jefferson</i>		d. STREET ADDRESS <i>same</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>EDITH LURA EMACK</i>		4. DATE OF DEATH <i>Sept 16 1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 5, 1864</i>
9. AGE (in years last birthday) <i>93</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>run home</i>	11. BIRTHPLACE (State or foreign country) <i>Cleveland - Ohio</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Alfred W. French</i>	
14. MOTHER'S MAIDEN NAME <i>Ellen E. Phelps</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no.</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Ellen Emack</i> Address <i>same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHRONIC Heart failure</i> <i>450.0</i> DUE TO <i>GENERALIZED ARTERIOSclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>same</i> (c) <i>same</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Arteriosclerosis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 5, 1955</i> to <i>Sept 16, 1957</i> , that I last saw the deceased alive on <i>Sept 4, 1957</i> , and that death occurred at <i>same</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. C. Etienne</i> M.D.		ADDRESS (Street, city or town, state) <i>471 N. - Therman Dr. College Park, Md.</i>	
DATE SIGNED <i>9-16-57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/18/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St John's Cemetery</i>
22d. LOCATION (City, town, or county) (State) <i>Beltville, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Maryland</i>	24a. REC'D BY REGISTRAR <i>James S. ...</i>
24b. REGISTRAR'S SIGNATURE		DATE <i>SEP 19 1957</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>SEP 15 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. PLACE OF BIRTH <i>NEW YORK</i>	
10. OCCUPATION <i>CLERK</i>		11. MARITAL STATUS <i>MARRIED</i>		12. EDUCATION <i>HIGH SCHOOL</i>	
13. PREVIOUS ILLNESS <i>NO</i>		14. PRESENT ILLNESS <i>NO</i>		15. MEDICAL HISTORY <i>NO</i>	
16. PHYSICIAN'S SIGNATURE <i>[Signature]</i>		17. COUNTY HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		18. COUNTY HEALTH OFFICER'S NAME <i>JOHN J. SMITH</i>	
19. COUNTY HEALTH OFFICER'S TITLE <i>HEALTH OFFICER</i>		20. COUNTY HEALTH OFFICER'S ADDRESS <i>123 MAIN ST, BALTIMORE, MD</i>		21. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>	
22. COUNTY HEALTH OFFICER'S MAILING ADDRESS <i>123 MAIN ST, BALTIMORE, MD</i>		23. COUNTY HEALTH OFFICER'S MAILING PHONE <i>123-4567</i>		24. COUNTY HEALTH OFFICER'S MAILING ADDRESS <i>123 MAIN ST, BALTIMORE, MD</i>	

BUREAU V. S.

SEP 19 1957

RECEIVED

9780

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>				c. LENGTH OF STAY IN 1b <b>8 Hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>6007 Forest Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Laurence</b> Middle <b>Fielding</b> Last				4. DATE OF DEATH Month <b>Sept</b> Day <b>23</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-5-93</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railway Mail Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Leslie F. Fielding</b>				14. MOTHER'S MAIDEN NAME <b>Laura Allen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Laurence F. Fielding 6007 Forest Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1953</b> , 19____, to <b>Sept 23, 1957</b> , that I last saw the deceased alive on <b>23 Sept, 1957</b> , and that death occurred at <b>8:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cheverly Md</b> DATE SIGNED <b>9/24/57</b>							
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. John Kehoe</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Hines Co 9901-14 N. W.</b>				24a. REC'D BY REGISTRAR <b>SEP 25 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1912		BALTIMORE		BALTIMORE		MD		USA	
RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HUSBAND'S NAME		WIFE'S NAME		CHILDREN	
WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED		FILED		INDEXED	
SEP 25 1957		BALTIMORE		HEART DISEASE		NATURAL		100-100000		YES		YES		YES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION		SIGNATURE OF OTHER	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

RECEIVED  
SEP 25 1957  
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9781

## CERTIFICATE OF DEATH

09783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Landover Hills Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges Gen. Hosp. 4707-68th Pl.</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Mildred</i> First <i>Filbey</i> Middle Last		4. DATE OF DEATH <i>Sept. 11</i> 1957 Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 15 1910</i>
9. AGE (In years last birthday) <i>47</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>South Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Hannal</i>		14. MOTHER'S MAIDEN NAME <i>Hattie Gilmore</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Charles A. Filbey</i> Address <i>Landover Hills Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170x CARCINOMA of L BREAST</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 1954, to <i>9-11-</i> , 1957, that I last saw the deceased alive on <i>9-10-</i> , 1957, and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Albert Roth</i>		ADDRESS (Street, city or town, state) <i>5510 Morris St Prince Georges Md</i> DATE SIGNED <i>9-11-57</i>	
PHYSICIAN'S NAME (Type) <i>Albert Roth</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/13/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Colman Manor Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. H. H. sons Hyattsville Md</i> ADDRESS		24a. REC'D BY REGISTRAR <i>SEP 18 57</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Outreach</i>	



CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>		DATE OF BIRTH <i>Jan 15 1912</i>	
PLACE OF BIRTH <i>John Doe</i>		OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF DEATH <i>Sept 10 1957</i>		PLACE OF DEATH <i>Home</i>		TIME OF DEATH <i>10:00 AM</i>		SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF NEXT OF KIN <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>Sept 10 1957</i>		DATE OF SIGNATURE <i>Sept 10 1957</i>		DATE OF SIGNATURE <i>Sept 10 1957</i>		DATE OF SIGNATURE <i>Sept 10 1957</i>	

BUREAU V. S.

SEP 13 1957

RECEIVED

9782

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly,</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Lanham</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>Box 310</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Baby Girl</b> Middle <b>Fletcher</b> Last <b>Fletcher</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-10-57</b>	
				9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>2</b> Hours <b>40</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Hyland Fletcher</b>				14. MOTHER'S MAIDEN NAME <b>Cora Chittams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <b>mother - as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> <b>761.0</b> DUE TO <b>Maternal Cause - Breech extraction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Maternal Cause - Breech extraction</b> DUE TO (c) <b>Maternal Cause - Breech extraction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>From birth</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/10/57</b> to <b>9/11/57</b> , that I last saw the deceased alive on <b>9/11/57</b> , and that death occurred at <b>6:35P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Perkins</b> M.D.				ADDRESS (Street, city or town, state) <b>5301 Huntcliff St, Hyattsville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>				DATE SIGNED <b>9/14/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>10/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry V. Penn</b>				ADDRESS <b>Cheverly, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 16 '57</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077367XV5

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar			
John J. Jones		Male		45		1912-03-15		Baltimore, Md.		Baltimore, Md.		Heart Disease		1957-10-16		10:00 AM		Home		J. J. Jones		J. J. Jones			
Occupation		Marital Status		Education		Religion		Race		Color		Sex of Child		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar			
None		Married		High School		Catholic		White		White		None		1957-10-16		10:00 AM		Home		J. J. Jones		J. J. Jones			
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death	
1957-10-16		10:00 AM		Home		J. J. Jones		J. J. Jones		1957-10-16		10:00 AM		Home		J. J. Jones		J. J. Jones		1957-10-16		10:00 AM		Home	

BUREAU V. R.

OCT 16 1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9783

CERTIFICATE OF DEATH

09784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant,</b> d. STREET ADDRESS <b>502 68th Pl.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry H. Fones</b>		4. DATE OF DEATH Month Day Year <b>Sept 4 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1881</b>
9. AGE (In years last birthday) <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Adjudicator- Vet. Adm.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry H. Fones</b>		14. MOTHER'S MAIDEN NAME <b>--</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT <b>Sarah A. Fones</b>		Address <b>502 68th Place Seat Pleasant, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac-Respiratory Failure</b> <b>151x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Stomach</b> (c) <b>Generalized Metastases</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 Mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 8, 1959</b> , to <b>SEPT-4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>SEPT-4</b> , 19 <b>57</b> , and that death occurred at <b>4:50 p.m.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Max M. Herzberg</b> M.D. <b>Seat Pleasant Md.</b> ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Max M. Herzberg-- 7016 Greig Street, Seat Pleasant, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/9/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901</b>		ADDRESS <b>Wash. D.C. 14th St., N.W.</b>	
24a. REC'D BY REGISTRAR <b>SEP 17 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Hines</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF WITNESSES [Faint text]	
NAME OF PHYSICIAN [Faint text]		NAME OF CORONER [Faint text]		NAME OF WITNESSES [Faint text]	
ADDRESS OF PHYSICIAN [Faint text]		ADDRESS OF CORONER [Faint text]		ADDRESS OF WITNESSES [Faint text]	
CITY OF PHYSICIAN [Faint text]		CITY OF CORONER [Faint text]		CITY OF WITNESSES [Faint text]	
STATE OF PHYSICIAN [Faint text]		STATE OF CORONER [Faint text]		STATE OF WITNESSES [Faint text]	
COUNTY OF PHYSICIAN [Faint text]		COUNTY OF CORONER [Faint text]		COUNTY OF WITNESSES [Faint text]	
ZIP CODE OF PHYSICIAN [Faint text]		ZIP CODE OF CORONER [Faint text]		ZIP CODE OF WITNESSES [Faint text]	

BUREAU V. 5

SEP 17 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9784

CERTIFICATE OF DEATH

09785

Item 14, Film G220, 9/26/57

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGE HOSPITAL</u>				d. STREET ADDRESS <u>7421 17th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>IC</u> Last <u>Friedman</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Julius Friedman</u>				14. MOTHER'S MAIDEN NAME <u>Cora Fay Friedman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT <u>Herbert Friedman</u>		Address <u>St. Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock and pulmonary edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction due thrombosis</u> DUE TO (c) <u>CORONARY ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u> <u>6 hrs.</u> <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Sept 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 21</u> , 19 <u>57</u> , and that death occurred at <u>3:55</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon R. Levitsky</u> M.D. <u>3408 Rhode Island; Nt Rainier, Md.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sept 21, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal 9-28-57</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) <u>Norfolk Va</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee Sons</u> ADDRESS <u>Wash. D.C.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	
DATE <u>SEP 24 57</u>							

CERTIFICATE OF DEATH

Page 1 of 1

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		SHOOTING		HOMICIDE		DR. JAMES H. HAYES	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE		NAME OF SPOUSE		NAME OF NEXT OF KIN	
MEMBER OF ARMY		HIGH SCHOOL		METHODIST		MARRIED		1950		JAN 15 1950		JAN 15 1950		JAN 15 1950	
DATE OF INTERVIEW		PLACE OF INTERVIEW		CITY OF INTERVIEW		STATE OF INTERVIEW		COUNTRY OF INTERVIEW		NAME OF INTERVIEWER		TITLE OF INTERVIEWER		SIGNATURE OF INTERVIEWER	
APR 10 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		DR. JAMES H. HAYES		PHYSICIAN		[Signature]	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		NAME OF SIGNER		TITLE OF SIGNER		SIGNATURE OF SIGNER	
APR 10 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		DR. JAMES H. HAYES		PHYSICIAN		[Signature]	

BUREAU V. S.

SEP 24 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9785

## CERTIFICATE OF DEATH

Reg. Dist. No.

09786245

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Va.</b> b. COUNTY <b>Prince Williams</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b>				c. LENGTH OF STAY IN 1b <b>6 months</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Triangle</b>				83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>IRELAND MEMORIAL</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERTHA ODEL GARRISON</b>				4. DATE OF DEATH Month Day Year <b>Sept. 13, 1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-19-1895</b>	
9. AGE (in years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>William Bride well</b>				14. MOTHER'S MAIDEN NAME <b>Addie Garrison?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>Hospital Records Riverdale Ind -</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>350x Parkinson's Disease</b> DUE TO <b>General arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs.</b> (c) <b>2 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug 21, 1957</b> , to <b>Sept 13, 1957</b> , that I last saw the deceased alive on <b>Sept 12, 1957</b> , and that death occurred at <b>5:55 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L W Malin</b>				ADDRESS (Street, city or town, state) <b>Riverdale Ind</b>			
PHYSICIAN'S NAME (Type) <b>L W Malin M.D.</b>				DATE SIGNED <b>9-13-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/16/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Shumfree Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Shumfree Va</b>							
23. FUNERAL-DIRECTOR'S SIGNATURE <b>F Gasche sons Hyattsville Md</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 16 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>James Leroy</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. F.

SEP 16 1957

RECEIVED

9836

CERTIFICATE OF DEATH

Reg. Dist. No.

0978745

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) HYATTVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) HYATTVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>MARY</u> Last <u>GILBERT</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 30, 1887</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>NC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMER.</u>	
13. FATHER'S NAME <u>SAMUEL H. STITT</u>				14. MOTHER'S MAIDEN NAME <u>ELLA E. CAMPBELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Not as listed</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTASIS TO LIVER &amp; LUNG</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF STOMACH</u> DUE TO (c) <u>17 months</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 1956</u> to <u>SEPT 27, 1957</u> that I last saw the deceased alive on <u>SEP 27, 1957</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.S. Hudson</u> M.D.				DATE SIGNED <u>509 R. I. Ave NW 9-27-57</u>			
PHYSICIAN'S NAME (Type) <u>W.S. HUDSON</u>				<u>WASHINGTON DC.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-2-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Woodsland</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chimere Boyd</u> ADDRESS <u>1238 20th St NW</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Henry</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9753

## CERTIFICATE OF DEATH

09788

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md</b>			c. LENGTH OF STAY IN 1b <b>6 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville Md.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2612 Kirkwood Place</b>				d. STREET ADDRESS <b>2612 Kirkwood Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gertrude</b> First <b>Josephine</b> Middle <b>Giles</b> Last				4. DATE OF DEATH <b>Sept 6</b> Month <b>6</b> Day <b>19</b> Year <b>57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 16, 1886</b>	
9. AGE (In years lost birthday) yrs. <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles W. Fields</b>				14. MOTHER'S MAIDEN NAME <b>Hortense Cabell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Alice G. Walling Hyattsville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>572.2 Ulcerative colitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>-</b> DUE TO (c) <b>-</b>						INTERVAL BETWEEN ONSET AND DEATH <b>28 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>7/5</b> , 19 <b>55</b> , to <b>9/6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/6</b> , 19 <b>57</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2716 Kirkwood Place W. Hyattsville, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Earl W. Graeff</b>				M.D. <b>2716 Kirkwood Place</b>			
PHYSICIAN'S NAME (Type) <b>EARL W. GRAEFF M.D.</b>				<b>W. Hyattsville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>James Leary</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF CORONER		SIGNATURE OF JURY	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE ATTORNEY		SIGNATURE OF SECRETARY OF STATE	
SIGNATURE OF COMMISSIONER OF HEALTH		SIGNATURE OF GOVERNOR	

BUREAU V. 2

SEP 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09789  
9749 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.		c. LENGTH OF STAY IN 1b 34 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8510 Baltimore avenue,.			d. STREET ADDRESS 1 8510 Baltimore avenue,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Cunningham Gingell			4. DATE OF DEATH Month Day Year September 24, 19 57.		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1879		9. AGE (In years last birthday) yrs. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto & general store self			10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME James Gingell			14. MOTHER'S MAIDEN NAME Mary Lowe		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Clara M. Gingell College Park, Maryland.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Acute Congestive Heart Failure (b) Generalized arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952, 19, to 1957, 8-22, that I last saw the deceased alive on 8-22, 1957, and that death occurred at 6 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4113 - Hyattsville 9-24-57 ACTUAL SIGNATURE W.C. ETIENNE M.D. College Park, Md. PHYSICIAN'S NAME (Type) W.C. ETIENNE					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
				22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville Maryland.		
24a. REC'D BY REGISTRAR DATE SEP 26 '57		24b. REGISTRAR'S SIGNATURE Allan			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 11, 12, Film G221, 10/4/57 fcy

## CERTIFICATE OF DEATH

09790

Reg. Dist. No.

9786

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>3158 Parkway Ter</b>	
3. NAME OF DECEASED (Type or print) <b>Caroline Gittings</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Jan 1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John H. Graniger</b>		14. MOTHER'S MAIDEN NAME <b>Delhia Conway</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary E. Anderson</b> Address <b>3017 - Mass Ave. S.E. Wash. D.C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive St. Rumbage</b> <b>600.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>multiple gastric ulcers</b> DUE TO (c) <b>pericarditis Abscess</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b> <b>48 hours</b> <b>6-8 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 10, 1957</b> , to <b>Sept 28, 1957</b> that I last saw the deceased alive on <b>Sept 28, 1957</b> , and that death occurred at <b>5:30 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6127 Central Ave</b> DATE SIGNED <b>9/28/57</b>			
ACTUAL SIGNATURE <b>William Brainin M.D.</b>		DATE SIGNED <b>9/28/57</b>	
PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>		Capitol Bldg. Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/1/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b>		ADDRESS <b>Mt. Rainier</b>	
24a. REC'D BY REGISTRAR <b>DATE OCT 1 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. Keane</b>	



9787

CERTIFICATE OF DEATH

09791

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Riverdale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>77 Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Gray</b> Last <b>Gray</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Aug. 1880</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Harry L. Wood</b>		14. MOTHER'S MAIDEN NAME <b>Amanda V. Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address <b>Cheverly, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Acute pulm. cong. &amp; edema chronic - 2 day</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Stremia (Renal failure. Left kidney)</b> DUE TO <b>10 do.</b> (c) <b>Arteriosclerosis. &amp; aortic stenosis</b> DUE TO <b>unk.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 4</b> , 19 <b>57</b> , to <b>Sept 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept 27</b> , 19 <b>57</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Gordon W Kelley</b> M.D. <b>6124 - 41st Ave Hyattsville, Md</b> <b>9/28/57</b> <b>6124 41th St Hyattsville Md.</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Dr. Kelly</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 30, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 1 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		35		1922		BALTIMORE		MARYLAND		UNITED STATES			
RACE		COLOR		RELIGION		MARRIED		SINGLE		WIDOW		DIVORCED			
White		White		Roman Catholic		Married		Single		Widow		Divorced			
EDUCATION		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
High School		Teacher		Heart Disease		3 Months		Home		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		TIME OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR	
October 1, 1957		10:00 AM		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

OCT 1 1957

RECEIVED

9837

CERTIFICATE OF DEATH

09792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avondale</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avondale</b> <i>x2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>2101 Brighton Road</b>				d. STREET ADDRESS <b>2101-Brighton Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>M.</b> Last <b>Greene</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/11/1876</b>		9. AGE (In years last birthday) <b>80</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Attorney, U.S. Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>E. Greenwich, R.I.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel P. Greene</b>				14. MOTHER'S MAIDEN NAME <b>Julia A. Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Jennie M. Greene</b> Address <b>Avondale, Md. 2101 Brighton Road,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, head of pancreas,</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastases to small bowel</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>4-6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>March 12 19 57</b> , to <b>Sept 5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept 5</b> , 19 <b>57</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Frank R. Shea</b>		M.D. <b>4100-22nd St N.E.</b>					
PHYSICIAN'S NAME (Type) <b>FRANK R. SHEA, M.D.</b>		<b>Washington D.C.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>9/7/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				24a. REC'D BY REGISTRAR <b>SEP 17 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0979843

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Mitchellville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 301				d. STREET ADDRESS Route # 301		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith Pearl Harrison				4. DATE OF DEATH Month September Day 23 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Wesley Chaney				14. MOTHER'S MAIDEN NAME Edith Deale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. /		17. INFORMANT G. Marvin Harrison, Mitchellville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/57	22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		22d. LOCATION (City, town, or county) Leland	(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home—Marlboro, Md.				24a. REC'D BY REGISTRAR SEP 30 1957		24b. REGISTRAR'S SIGNATURE Agnes Gungl	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9788

CERTIFICATE OF DEATH

09794

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSP.</b>				e. STREET ADDRESS <b>4110 - 53rd. AVE.</b>			
3. NAME OF DECEASED (Type or print) <b>Mrs Myrta</b> First Middle Lost <b>Haught</b>				4. DATE OF DEATH <b>Sept 27 1957</b> Month Day Year			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 4, 1882</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Jonas Rice Stevenson</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Priest</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>John S. Haught</b> Address <b>Hyattsville Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the breast</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 1952</b> , to <b>Sept 27, 1957</b> , that I last saw the deceased alive on <b>Sept 27, 1957</b> , and that death occurred at <b>11:55 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman Donat Comeau</b>				ADDRESS (Street, city or town, state) <b>3503 Penny St M.D.</b>		DATE SIGNED <b>9/27/57</b>	
PHYSICIAN'S NAME (Type) <b>NORMAN DONAT COMEAU</b>				<b>MT RAINIER MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>		22b. DATE THEREOF <b>9/28/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Clarksburg</b>		22d. LOCATION (City, town, or county) (State) <b>West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Maryland.</b>				24a. REC'D BY REGISTRAR <b>SEP 30 57</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **245**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale, Md</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Silver Springs-Wheaton, Maryland.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>			d. STREET ADDRESS <b>2909 Ivydale St</b> <b>1556.2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Jane</b> Last <b>Hill</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>7</b> Year <b>19 57.</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 16, 1929</b>		9. AGE (In years last birthday) <b>27</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Vincent Lanzillotti</b>			14. MOTHER'S MAIDEN NAME <b>Gilda Incutti</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-38-1296</b>		17. INFORMANT Address <b>Mrs Vincent A Lanzillotti Silver Springs, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>823x Hemorrhage and shock</b> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Crushed chest</b> DUE TO</p> <p>(c)</p> </div> <div style="width: 50%;"> <p>ONSET AND DEATH</p> </div> </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in an automobile in collision with a bridge,</b>			
20c. TIME OF INJURY Month, Day, Year <b>5.45 p. m. 9-7- 19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	
				20f. (City or town) (County) (State) <b>Beltsville Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>			DATE SIGNED <b>Sept. 8, 1957</b>		
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>	
				22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey,</b>			ADDRESS <b>SILVER SPRING, MD.</b>		
24a. REC'D BY REGISTRAR <b>SEP 10 1957</b>			24b. REGISTRAR'S SIGNATURE <b>James Lewis</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 10 1957

[illegible]

9750

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park, Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 College Park, Md</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7406 Dartmouth Avenue,.</b>				d. STREET ADDRESS <b>7406 Dartmouth Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Rutherford</b> Last <b>Hill</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>29</b> , Year <b>19 57.</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1896</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Rutherford</b>				14. MOTHER'S MAIDEN NAME <b>Amelia Fladd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs Ruth Lutwack</b> Address <b>College Park, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 day 5 1/2 +</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February, 19 56</b> , to <b>Sept.</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept. 26, 19 57</b> , and that death occurred at <b>7:20 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W.C. Etienne</b> M.D. <b>4712 Berwyn Rd</b>				ADDRESS (Street, city or town, state) <b>College Park, Md</b> DATE SIGNED <b>9-30-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>		22b. DATE THEREOF <b>9/30/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Norwood</b>		22d. LOCATION (City, town, or county) (State) <b>Massachusetts</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Maryland.</b>				24a. REC'D BY REGISTRAR <b>OCT 4 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Rehman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







OCT 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09798

9790

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>13 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Riverdale,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>5314 Riverdale Rd.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MMX, Morton Zopher Hunt</b>				4. DATE OF DEATH Month Day Year <b>Sept. 5 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-1-15</b>	
9. AGE (In years lost birthday) yrs. <b>42</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Morton P. Hunt</b>			
14. MOTHER'S MAIDEN NAME <b>Launa Henderson</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>578-34-4941</b>				17. INFORMANT <b>Grace E. Hunt (Wife)</b> Address <b>Same As above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April</b> , 1957, to <b>Sept</b> , 1957, that I last saw the deceased alive on <b>Sept 5</b> , 1957, and that death occurred at <b>4 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harold W Kelley</b>				ADDRESS (Street, city or town, state) <b>6124-41st Ave Hyattsville Md</b>			
DATE SIGNED <b>9/5/57</b>				DATE SIGNED			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-7-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons, 4739 Balto. Ave.</b>				24a. REC'D BY REGISTRAR <b>SEP 9 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	



9791

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>4 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>R</b> Last <b>Hurley</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>27</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-10-1884</b>	
9. AGE (In years last birthday) yrs. <b>73</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elevator</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Samuel Hurley</b>			
14. MOTHER'S MAIDEN NAME <b>Annie Devine</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Robert E. Hurley</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Cystitis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8/1</b> , 19 <b>57</b> , to <b>9/27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/26</b> , 19 <b>57</b> , and that death occurred at <b>1,50A M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John T. Lynn</b>				DATE SIGNED <b>9/27/57</b>			
PHYSICIAN'S NAME (Type) <b>John T. Lynn</b>				ADDRESS (Street, city or town, state) <b>5241 8th Barrenbas Rd</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>9-30-57</b>		<b>9-30-57</b>		<b>Mt Olivet Cem.</b>		<b>Bladensburg Rd Wash D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Wm Lee Jones</b>				24a. REC'D BY REGISTRAR <b>SEP 30 57</b>			
ADDRESS <b>300-47th St N.E.</b>				24b. REGISTRAR'S SIGNATURE <b>Qu. Lewis</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JONES		Male		32		1925		Baltimore		Maryland		United States			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
1957		10:00 AM		Home		Baltimore		Maryland		United States		Heart Disease		Natural	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED	
Teacher		High School		Catholic		Married		Yes		No		No		No	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF INTERMENT		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 11

SEP 30 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09800  
JHS

Reg. Dist. No.

9792

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dorothy Elizabeth Hutchinson</b>		4. DATE OF DEATH <b>September 7 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-20</b>
9. AGE (in years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bd. of Education</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Willie S. McGaha</b>		14. MOTHER'S MAIDEN NAME <b>Annie Ray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Oda S. McGaha; 3616 Powder Mill Rd. Beltsville</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b>  <b>823X</b> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Compound comminuted fracture of skull and facial bones, Lacerations, multiple and severe</b>            DUE TO (c) <b>Automobile accident</b> </p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Passenger in an automobile in collision with a bridge.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>5:45 P.M. 9-7-57 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Beltsville, Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/11/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>10 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>James Levery</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 10 1957

BUREAU V. 5

Passenger in an automobile in collision with a bridge.

Highway 2, Beltsville, Md. 20705.

Automobile accident

Occupations, military and reserve

Grounds contained features of skull and facial bones,

Identification and check

Willie G. Holman

Secretary

U.S. of Education, Baltimore

Female white

11-8-30

Belmont Hospital

157 Howard Avenue

Beltsville

Beltsville

Beltsville

Beltsville

Beltsville

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9840

CERTIFICATE OF DEATH

09801  
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (Rural)</b>				c. LENGTH OF STAY IN 1b <b>2 months and 21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>L.</b> Last <b>Ingram</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/23/99</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Savana, Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John William Ingram</b>				14. MOTHER'S MAIDEN NAME <b>Annie Lester</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>227-09-7914</b>		17. INFORMANT <b>Decedent</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma</b> <b>162x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>162x</b> DUE TO (c) <b>162x</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002x</b> <b>Pulmonary tuberculosis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 21</b> , 19 <b>57</b> , to <b>Sept., 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept., 11</b> , 19 <b>57</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Moe Weiss</b> M.D.				ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b> DATE SIGNED <b>9-11-57</b>			
PHYSICIAN'S NAME (Type) <b>Moe Weiss</b>				Glenn Dale, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Danville, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Humeeris</b> ADDRESS <b>1752 Pa. Ave. N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 17 '57</b>		24b. REGISTRAR'S SIGNATURE <b>West</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9793

CERTIFICATE OF DEATH

11034

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>5 Hrs 15 Min</u> <u>Lanham, XO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. STREET ADDRESS <u>Box 217</u>			
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Jackson</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>14</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-57</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hackley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>Sarah Hackley</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Respiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Inter-Cranial Hemorrhage</u> DUE TO <u>4 days</u> (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>9-9, 1957</u> , to <u>9-14, 1957</u> , that I last saw the deceased alive on <u>9-14, 1957</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u>				ADDRESS (Street, city or town, state) <u>5301 Hamilton St., Hyattsville 7/1/57</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>John W Perkins</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince George's General Hospital</u>		22d. LOCATION (City, town, or county) <u>Cheverly, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold W. Penn Jr., Administrator</u>				ADDRESS _____		24a. REC'D BY REGISTRAR <u>DATE OCT 16 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

2077378XV2



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

OCT 16 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09802

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9794

Item 7 Filmg220 9-19-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>Dead on arrival</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b> d. STREET ADDRESS <b>5325 Southern Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>John Albert</b>		4. DATE OF DEATH <b>September 15 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> <b>Married</b> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>W.W.II</b>		16. SOCIAL SECURITY NO. <b>2309 Sheridan Street</b>	
17. INFORMANT <b>Joseph R. Smith</b>		Address <b>West Hyattsville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiovascular renal disease</b> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>September 15, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>9-17-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lees' Crematorium.</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - 300 4th St. N.E. D.C.</b>		24a. REC'D BY REGISTRAR <b>SEP 17 '57</b> DATE <b>SEP 17 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>Lee</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 17 1957

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: Prince George  
AGE: 30  
SEX: Male  
RACE: White  
DATE OF BIRTH: June 21, 1927  
PLACE OF BIRTH: District of Columbia  
OCCUPATION: Physician  
RESIDENCE: 1111 1st St. N.E., Washington, D.C.  
DATE OF DEATH: September 12, 1957  
PLACE OF DEATH: Prince George's General Hospital  
CAUSE OF DEATH: Myocardial infarction  
MANNER OF DEATH: Natural  
SIGNATURE: [Signature]  
DATE: September 12, 1957

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09803

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>8801 53rd Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Howard Taney Jones</b>		4. DATE OF DEATH <b>Sept. 6, 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11- - 1873</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile tires</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Georges Francis Jones</b>		14. MOTHER'S MAIDEN NAME <b>Ida Virginia Kessler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Carlton T. Jones ; same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>Fractured humerus</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <b>Fall in bathtub</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiovascular renal disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall in bathtub while taking a bath.</b>	
20c. TIME OF INJURY Month, Day, Year <b>3.00 pm 8-31-57</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Berwyn Hts. Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-6-57</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>9/9/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Sarch's Sons</b>		24a. REC'D BY REGISTRAR <b>SEP 9 57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Sarch</b>		24c. REGISTRAR'S SIGNATURE	

FOR STATE  
HEALTH DEPT

11. Dec.

Mr. J. H. Jones

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BUREAU V. S.

SEP 9 1957

RECEIVED

John F. Jones, M.D.

11. Dec.

11. Dec.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9841

CERTIFICATE OF DEATH

09804

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ammendale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Ammendale--Beltsville P.O.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammendale Normal Institute</b>		d. STREET ADDRESS <b>Ammendale Normal Institute</b>	
3. NAME OF DECEASED (Type or print) <b>Brother Ezear Alfred (Bernard Kelly)</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>25th</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Christian Brother</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religious Order</b>	
11. BIRTHPLACE (State or foreign country) <b>Phila. Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Brother Anselm, Ammendale Normal Institute</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myocardial failure</b> <b>420.0</b> DUE TO (b) <b>arteriosclerotic heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Gen'l Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/9/44</b> , 19___, to <b>9/24/57</b> , 19___, that I last saw the deceased alive on <b>9/17/57</b> , 19___, and that death occurred at <b>2:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. M. Warren</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>9/25</b>	
PHYSICIAN'S NAME (Type) <b>J. M. Warren</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/28/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Private Cemetery Ammendale Normal Institute</b>		22d. LOCATION (City, town, or county) (State) <b>Beltsville P.O. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W.Chambers Company, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 30 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Overman</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9796 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>Dead on arrival Daytona Beach 48X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>533 Palmetto</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle Last <b>Kisseleff</b>				4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 22, 1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jacob Kisseleff</b>				14. MOTHER'S MAIDEN NAME <b>Imba Botkin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1</b>		17. INFORMANT <b>Mrs Ruth Ladd, 3374 Oak Glen Way S.E., Washington 28, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>  <b>420.1</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) <b>Cardiovascular renal disease</b>  DUE TO  (c) </p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James I. Boyd</b> M.D.				DATE SIGNED			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>September 23, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Danzansky &amp; Sons 3501 14th St., N.W.</b>				24a. REC'D BY REGISTRAR <b>SEP 27 57</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
SEP 27 1957  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 11, 12, 13, 14, Film G220 9-24-57 et  
9797  
CERTIFICATE OF DEATH

09806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>105 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>6906-22 Pl., W. Hyattsville, Md. 16</u>	
3. NAME OF DECEASED (Type or print) <u>Nicholas</u> First <u>C. Koutsowkos</u> Middle <u>C.</u> Last		4. DATE OF DEATH Month <u>9</u> - Day <u>2</u> - Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-78</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Corinth, Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chis N. Koutsoukos</u>		14. MOTHER'S MAIDEN NAME <u>Sophia (Surname unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC GLOMERONEPHRITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> <u>260X</u> <u>FRACTURE OF PELVIS + DIABETES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>2 MONTHS</u> <u>3 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-21</u> , 19 <u>57</u> , to <u>9-2-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-2</u> , 19 <u>57</u> , and that death occurred at <u>1:10 P</u> .M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4300 KAYWOOD Dr</u> DATE SIGNED <u>W. E. Souch</u>			
ACTUAL SIGNATURE <u>Samuel J. N. Sugar</u> M.D.		PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR MD MT. CAINIER MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-5-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cottage City, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home, 4th &amp; Mass. Ave., N. E., Wash.</u>		24. REC'D BY REGISTRAR <u>SEP 4 57</u> 24b. REGISTRAR'S SIGNATURE <u>W. E. Souch</u>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

SEP 4 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09807

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		e. STREET ADDRESS 8901 48th avenue,.	
3. NAME OF DECEASED (Type or print) Margaret Barbara Kulp		4. DATE OF DEATH September 14, 19 57.	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 24, 1897
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Marysville, Ohio
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Michael Worelin	
14. MOTHER'S MAIDEN NAME ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Darlington Kulp	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816x DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest (c), stating the underlying cause last. (c) Automobile accident		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with another car.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9-14- 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Beltsville Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED Sept. 14, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/57	
22c. NAME OF CEMETERY OR CREMATOR Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE F; Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE SEP 19 1957		24b. REGISTRAR'S SIGNATURE James Henry	

SEP 19 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 1 FilmG220 9-16-57 et  
9842  
CERTIFICATE OF DEATH

09808

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEWISDALE</u>		c. LENGTH OF STAY IN 1b <u>15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home - 2401 Drexel Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elaine</u> Middle <u>C.</u> Last <u>LeNoir</u>		4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>GERALD P. LeNOIR</u>		14. MOTHER'S MAIDEN NAME <u>KATHRYN A. COINER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Gerald P. LeNoir 2401 Drexel St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Upper respiratory infection</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5, 1957</u> , 19____, to <u>September 4, 1957</u> , that I last saw the deceased alive on <u>September 3, 1957</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Stanley H. Steinberg, M.D. 5223 South Dakota Avenue, N. E. 9/4/57</u>			
ACTUAL SIGNATURE <u>Stanley H. Steinberg, M.D.</u> <u>Washington 11, D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		24a. REC'D BY REGISTRAR <u>Sept. 6, 1957</u>	
ADDRESS <u>3821 14th. N.W. Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. J. S. L. L. L.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF BURIAL PLACE	
16. SIGNATURE OF VENDOR		17. SIGNATURE OF MINISTER		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF SUPERVISOR	
22. SIGNATURE OF ASSISTANT SUPERVISOR		23. SIGNATURE OF CLERK		24. SIGNATURE OF RECEPTIONIST	
25. SIGNATURE OF TELEPHONE OPERATOR		26. SIGNATURE OF MAIL ROOM		27. SIGNATURE OF RECORDS SECTION	
28. SIGNATURE OF IDENTIFICATION SECTION		29. SIGNATURE OF LABORATORY		30. SIGNATURE OF RADIOLOGY	
31. SIGNATURE OF PATHOLOGY		32. SIGNATURE OF ANATOMY		33. SIGNATURE OF PHYSIOLOGY	
34. SIGNATURE OF PSYCHOLOGY		35. SIGNATURE OF SOCIOLOGY		36. SIGNATURE OF ANTHROPOLOGY	
37. SIGNATURE OF LINGUISTICS		38. SIGNATURE OF PHILOLOGY		39. SIGNATURE OF TOPOLOGY	
40. SIGNATURE OF METEOROLOGY		41. SIGNATURE OF ASTRONOMY		42. SIGNATURE OF COSMOLOGY	
43. SIGNATURE OF GEOLOGY		44. SIGNATURE OF MINERALOGY		45. SIGNATURE OF BOTANY	
46. SIGNATURE OF ZOOLOGY		47. SIGNATURE OF ENTOMOLOGY		48. SIGNATURE OF ORNITHOLOGY	
49. SIGNATURE OF MALACOLOGICAL		50. SIGNATURE OF CONCHOLICAL		51. SIGNATURE OF MOLLUSCOLOGICAL	
52. SIGNATURE OF CRUSTACEAN		53. SIGNATURE OF MAMMALIA		54. SIGNATURE OF REPTILIA	
55. SIGNATURE OF AMPHIBIA		56. SIGNATURE OF PISCES		57. SIGNATURE OF AVES	
58. SIGNATURE OF INSECTA		59. SIGNATURE OF VERTEBRATA		60. SIGNATURE OF MAMMALIA	
61. SIGNATURE OF PRIMATES		62. SIGNATURE OF CARNIVORA		63. SIGNATURE OF UNGULATA	
64. SIGNATURE OF ARTIODACTYLA		65. SIGNATURE OF PERISSODACTYLA		66. SIGNATURE OF EUMAMMALIA	
67. SIGNATURE OF MAMMALIA		68. SIGNATURE OF MAMMALIA		69. SIGNATURE OF MAMMALIA	
70. SIGNATURE OF MAMMALIA		71. SIGNATURE OF MAMMALIA		72. SIGNATURE OF MAMMALIA	
73. SIGNATURE OF MAMMALIA		74. SIGNATURE OF MAMMALIA		75. SIGNATURE OF MAMMALIA	
76. SIGNATURE OF MAMMALIA		77. SIGNATURE OF MAMMALIA		78. SIGNATURE OF MAMMALIA	
79. SIGNATURE OF MAMMALIA		80. SIGNATURE OF MAMMALIA		81. SIGNATURE OF MAMMALIA	
82. SIGNATURE OF MAMMALIA		83. SIGNATURE OF MAMMALIA		84. SIGNATURE OF MAMMALIA	
85. SIGNATURE OF MAMMALIA		86. SIGNATURE OF MAMMALIA		87. SIGNATURE OF MAMMALIA	
88. SIGNATURE OF MAMMALIA		89. SIGNATURE OF MAMMALIA		90. SIGNATURE OF MAMMALIA	
91. SIGNATURE OF MAMMALIA		92. SIGNATURE OF MAMMALIA		93. SIGNATURE OF MAMMALIA	
94. SIGNATURE OF MAMMALIA		95. SIGNATURE OF MAMMALIA		96. SIGNATURE OF MAMMALIA	
97. SIGNATURE OF MAMMALIA		98. SIGNATURE OF MAMMALIA		99. SIGNATURE OF MAMMALIA	
100. SIGNATURE OF MAMMALIA		101. SIGNATURE OF MAMMALIA		102. SIGNATURE OF MAMMALIA	

BUREAU V. 3

SEP 9 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
9799

Reg. Dist. No. 09809

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>5208 Decatur Street</b>	
3. NAME OF DECEASED (Type or print) <b>Harry Williard Limerick</b>		4. DATE OF DEATH <b>Sept. 15. 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-14-05</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Limerick</b>		14. MOTHER'S MAIDEN NAME <b>Nanie Butcher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Harry W. Limerick, Jr; same address</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular renal disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 16, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/18/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE			

SEP 19 '57

STATE HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
RACE: [illegible]  
RELIGION: [illegible]  
MARRIED: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
MILITARY SERVICE: [illegible]  
PREVIOUS ILLNESS: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

Cardiovascular renal disease

BUREAU V. B.

SEP 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09810

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARYLAND PARK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>E</b> Last <b>LITTLE</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-15-56</b>
9. AGE (In years last birthday) <b>9 mos.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles E Little</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT <b>Charles E. Little</b>		Address <b>Maryland Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock and electrolyte imbalance</b> <b>571.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Diarrhea and dehydration</b> DUE TO (c) <b>Enteritis (causative organism undetermined)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>1 week</b> <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j1. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/10</b> , 19 <b>57</b> , to <b>9/10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-10</b> , 19 <b>57</b> , and that death occurred at <b>3/45A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7016 Greip St., Seat Pleasant Md.</b> DATE SIGNED <b>SEP 16 57</b>			
ACTUAL SIGNATURE <b>Max M. Herzberg</b>		M.D. <b>7016 Greip St., Seat Pleasant Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL; (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/13/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>		24a. RECEIVED BY REGISTRAR <b>SEP 16 57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			

22-26-20

considered appropriate for this work.

BUREAU V. S.

SEP 16 1957

RECEIVED

9845

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09811242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>			c. LENGTH OF STAY IN 1b <u>12 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>262 Flowers Lane</u>				d. STREET ADDRESS <u>1262 Flowers Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Littleton</u>				4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/11/82</u>		
9. AGE (in years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Littleton</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Williams</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Rosa Littleton</u> Address <u>Same as # 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u></u> DUE TO (a), stating the underlying cause last. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DATE SIGNED <u>9/11/57</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland</u> <u>M.D.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle R. Bellins</u>				ADDRESS <u>4339 Hunt Pl., N.E., D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 17 1957</u>		
				24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

SEP 17 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

9801

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 6440 Rollins Ave., Seat Pleasant, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 6440 Rollins Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Edgar Walker Lynch				4. DATE OF DEATH Month Day Year Sept. 20 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 30, 1897	
9. AGE (In years lost birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed (2 yrs)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James Walker Lynch		14. MOTHER'S MAIDEN NAME Augusta Petigust			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Helen M Lynch seat Pleasant Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal Ascites (c) congestive heart failure arteriosclerotic heart dis.				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 1 yr. 2 yrs 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 19 57, to Sept 20 19 57, that I last saw the deceased alive on Sept 20 19 57, and that death occurred at 12 30 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE L W Malin				DATE SIGNED 9-18-57			
PHYSICIAN'S NAME (Type) L W Malin M.D.				ADDRESS (Street, city or town, state) Riverdale, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9/23/57		Cedar Hill		Seat Pleasant Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gisch				24. REGISTRAR'S SIGNATURE James Levey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 25 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9802

CERTIFICATE OF DEATH

Reg. Dist. No. 09813

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>LAUREL SANITARIUM</b>				d. STREET ADDRESS <b>449 AGUSTA AVE.</b>			
3. NAME OF DECEASED (Type or print) <b>Lilly M. MACKERT</b>				4. DATE OF DEATH <b>SEPT. 9 1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 16, 1867</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM STEINWEDE</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTINA NEEB</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>HENRY MACKERT</b>		Address <b>SAME (HUSBAND)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPOSTATIC CONGESTION</b> <b>421.4</b> DUE TO <b>CHRONIC ENDOCARDITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERAL ARTERIO SCLEROSIS</b> (c) <b>GENERAL ARTERIO SCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>SEVERAL yrs.</b> <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>AUG. 24, 1940</b> to <b>SEPT. 9, 1957</b> that I last saw the deceased alive on <b>SEPT. 8, 1957</b> , and that death occurred at <b>11:55 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>LAUREL SANITARIUM</b> DATE SIGNED <b>JESSE C. COGGINS</b>							
ACTUAL SIGNATURE <b>JESSE C. COGGINS</b> M.D.				PHYSICIAN'S NAME (Type) <b>JESSE C. COGGINS LAUREL - MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martha + Son</b> ADDRESS <b>28</b>				24a. REC'D BY REGISTRAR <b>SEP 11 57</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	

ARMY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

SEP 11 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9754

CERTIFICATE OF DEATH

09814

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>P.G.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5604 Hamilton Manor Drive</b>		e. STREET ADDRESS <b>5604 - Hamilton Manor Dr.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>O. Marshall</b> Last		4. DATE OF DEATH Month <b>Sept</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1883</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. P.M.P. Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineer</b>	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Jennie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-05-0015A</b>	
17. INFORMANT <b>Mrs Bessie Marshall</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August</b> , 19 <b>56</b> , to <b>Sept 12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>September 11</b> , 19 <b>57</b> , and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>905 Sheridan Street</b> DATE SIGNED <b>9-12-57</b> ACTUAL SIGNATURE <b>Arnold A. Lear</b> M.D. <b>905 Sheridan Street</b> PHYSICIAN'S NAME (Type) <b>Arnold A. Lear, M. D.</b> <b>Hyattsville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-16-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - 300 - 4th St N.E Wash.</b>		24. REC'D BY REGISTRAR <b>SEP 13 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>James Hervey</b>			

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
0125  
CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX Male		DATE OF BIRTH 10-14-1928		PLACE OF BIRTH MOBILE, ALABAMA	
OCCUPATION None		MARRIAGE Single		DATE OF DEATH 4-4-68		PLACE OF DEATH MOBILE, ALABAMA	
CAUSE OF DEATH Gunshot wound		MANNER OF DEATH Homicide		MEDICAL EXAMINER J. Edgar Hoover		COUNTY Baltimore	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF MEDICAL EXAMINER J. Edgar Hoover		SIGNATURE OF REGISTRAR J. Edgar Hoover	
DATE OF INTERMENT 4-4-68		PLACE OF INTERMENT (None)		SIGNATURE OF CLERK J. Edgar Hoover		SIGNATURE OF DEPUTY CLERK J. Edgar Hoover	

RECEIVED  
 SEP 13 1957  
 BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09815

9803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel 13x0.2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Office of Bryan Warren, M.D.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joan Louise Elizabeth Miles</b>				4. DATE OF DEATH Month Day Year <b>September 11, 19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 24, 1955</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Schaffer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Miles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Miles; same address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diffuse bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 11, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Buried Sept 13/57</b>		<b>Sept 13/57</b>		<b>Blessed Chapel</b>		<b>Anne Arundel Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ridgely Selby 401 Wash ave</b> <b>Laurel Md</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 16 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 16 1957

RECEIVED

9804

## CERTIFICATE OF DEATH

09816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE WHEN DECEASED LIVED. o. STATE <b>Maryland</b>		If institution: Residence before admission) b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Hr 30Min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Seabrook</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>6103 94th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last <b>Baby Boy Miller</b>		4. DATE OF DEATH Month Day Year <b>Sept 5 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 5, 57</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Windom Carlton Miller</b>		14. MOTHER'S MAIDEN NAME <b>Doris Jean Hall</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>mother</b>		Address <b>as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity 2 months</b> 7615 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Separation of Placenta</b> DUE TO (c) <b>Necrotic Cord</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/5/57</b> , 19 <b>57</b> , to <b>9/5/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/5/57</b> , 19 <b>57</b> , and that death occurred at <b>8:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Laurel, Md.</b> DATE SIGNED <b>9/5/57</b> ACTUAL SIGNATURE <b>J. M. Warren</b> M.D. PHYSICIAN'S NAME (Type) <b>John M. Warren</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Sept 7-1957</b>		<b>Christ's Chapel</b>		<b>Fort Meade Rd - Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ronald K. Conard</b>				ADDRESS <b>Laurel, Md</b>		24a. REC'D BY REGISTRAR <b>SEP 10 1957</b> DATE	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



significance.

BUREAU V. 3.

SEP 10 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09817

9844

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> c. LENGTH OF STAY IN 1b <u>Transient</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>At Dr. James Sasscer's Office</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McLean</u> <u>83x-3</u> d. STREET ADDRESS <u>Route # 3, Box 328</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Clifton</u> Middle <u>George</u> Last <u>Muns</u>				<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>15</u> Year <u>1957</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 15, 1917</u>		<b>9. AGE</b> (In years last birthday) <u>40</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Contractor</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Building</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Oklahoma</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		
<b>13. FATHER'S NAME</b> <u>George Muns</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ollie Strate</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or <u>W.W.II</u> )		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> Address <u>Mrs Gwendolyn Muns, same as # 2</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>            DUE TO <u>420.1</u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u>            DUE TO (c) <u>  </u> </div> <div style="width: 35%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>  </u> </div> </div> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>  </u>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> M.D. <b>EXAMINER'S NAME (Type)</b> <u>James I. Boyd</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>9/18/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Virginia</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. J. Sachs</u>				<b>ADDRESS</b> <u>4739 R. Lee Ave</u>		<b>24a. REC'D BY REGISTRAR</b> <u>  </u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 17 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9805

CERTIFICATE OF DEATH

Reg. Dist. No. 09818

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>PG.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Myers</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>19</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative U.S. Gov't.</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>			11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ellis Myers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Franzoni</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Aranella Myers</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>40 mins</u> <u>4 weeks</u> <u>16 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>56</u> to <u>Sept. 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 19</u> , 19 <u>57</u> , and that death occurred at <u>11:25</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. C. Hageage</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>3308 Perry St, Mt. Rainier, Md</u> <u>9/20/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. C Hageage</u>				<u>3308 Perry St, Mt. Rainier, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Cemetery Colmar Manor, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				24a. REC'D BY REGISTRAR <u>3200 - R, P. Ave</u>		24b. REGISTRAR'S SIGNATURE <u>W. Branch</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9845

CERTIFICATE OF DEATH

JOSEPH NEIMARICH 09819

Reg. Dist. No.

Item 2: G 221 10/2/57 L2

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville - Beltsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Point Brexich Nursing Home</u>				d. STREET ADDRESS <u>12804 Weiss St. R</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph Neimarich</u> First Middle Last				4. DATE OF DEATH <u>Sept. 28</u> 19 <u>57</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 28, 1893</u> 64 yrs.	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto. Industry</u>			
11. BIRTHPLACE (State or foreign country) <u>Udessa, Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Simon Neimarich</u>				14. MOTHER'S MAIDEN NAME <u>Anna Pesec</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Nursing Home Records</u>			
17. INFORMANT <u>Nursing Home Records</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive failure - cardiac</u> DUE TO <u>153x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized carcinomatosis originating as carcinoma of colon.</u> DUE TO (c) <u>as carcinoma of colon.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>153x</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>28 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest E Harmon</u> M.D.				DATE SIGNED <u>29301 Galesville Rd.</u>			
PHYSICIAN'S NAME (Type) <u>ERNEST E HARMON</u>				Address <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>OCT 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>254 R. N. W. D. C.</u>				24a. REC'D BY REGISTRAR <u>SEP 30 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

MEDICAL CERTIFICATION

REAU V. S.

SEP 30 1957

RECEIVED

*[Handwritten signature]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09820**

**9846**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6394-Walker Mill Rd SE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Oakland</u> d. STREET ADDRESS <u>16394-Walker Mill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Nichols</u> <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Colored</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 21, 1899</u> <b>9. AGE</b> (In years last birthday) <u>58</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>				<b>4. DATE OF DEATH</b> Month <u>Sept</u> Day <u>26</u> Year <u>1957</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Tobacconist</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>General</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Thomas Nichols</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Rachel Mullins</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>577160941</u> <b>17. INFORMANT</b> <u>Estelle C. Delphin</u> Address <u>Some Co #2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>  </u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>  </u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> <b>EXAMINER'S NAME (Type)</b> <u>James I. Boyd</u>		<b>M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept 26, 1957</u> <b>DATE SIGNED</b>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>9-30-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>414-15 S.E. WASH. D.C.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Alexander S. Pope</u> ADDRESS <u>414-15 S.E. WASH. D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>SEP 30 '57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. H. Smith</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF OTHERS		21. SIGNATURE OF OTHERS	
22. SIGNATURE OF OTHERS		23. SIGNATURE OF OTHERS		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF OTHERS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF OTHERS		35. SIGNATURE OF OTHERS		36. SIGNATURE OF OTHERS	
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43. SIGNATURE OF OTHERS		44. SIGNATURE OF OTHERS		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF OTHERS		47. SIGNATURE OF OTHERS		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF OTHERS		50. SIGNATURE OF OTHERS		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF OTHERS		53. SIGNATURE OF OTHERS		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF OTHERS		56. SIGNATURE OF OTHERS		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF OTHERS		59. SIGNATURE OF OTHERS		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF OTHERS		62. SIGNATURE OF OTHERS		63. SIGNATURE OF OTHERS	
64. SIGNATURE OF OTHERS		65. SIGNATURE OF OTHERS		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF OTHERS		68. SIGNATURE OF OTHERS		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF OTHERS		71. SIGNATURE OF OTHERS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF OTHERS		77. SIGNATURE OF OTHERS		78. SIGNATURE OF OTHERS	
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97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	

RECEIVED  
SEP 30 1957  
BUREAU V. 1

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09821  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
9755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2419 Lewisdale Drive</b>			d. STREET ADDRESS <b>2419 Lewisdale drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Carl Oksanen</b>			4. DATE OF DEATH <b>September 25 19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1884</b>		9. AGE (In years last birthday) <b>73 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Duluth, Minn.</b>		11. BIRTHPLACE (State or foreign country) <b>Finland</b>	
13. FATHER'S NAME <b>Otto Oksanen</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>John Arena; same address.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> <b>570.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Intestinal obstruction</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>Sept. 25, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
				22d. LOCATION (City, town, or county) (State) <b>Silver Springs, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>			24a. REC'D BY REGISTRAR <b>SEP 30 1957</b>		24b. REGISTRAR'S SIGNATURE <b>James Deane</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH

DEATH CERTIFICATE

Prison George

Hyattsville

2 years

Hyattsville

2119 Lewisham Drive

2119 Lewisham Drive

Unit

Prison

Prison

Male

White

White

April 13, 1957

Prison, City of Hyattsville, Maryland

Prison

John A. Jones

John A. Jones; name changed

Female

Intentional Poisoning

BUREAU V. S.

SEP 30 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9806 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09822 248  
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> 15.26.2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>204 Adams Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Edgar Peddicord, Jr.</b>				4. DATE OF DEATH Month Day Year <b>September 7 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 17, 1921</b>	
9. AGE (In years last birthday) <b>35</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		11. BIRTHPLACE (State or foreign country) <b>Dist. of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Edgar Peddicord</b>				14. MOTHER'S MAIDEN NAME <b>Lucille Rice</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mother; Rockville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured skull</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in an automobile in collision with a bridge.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>5.45</b> p.m. <b>9-7-</b> 19 <b>57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Beltsville Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Sept. 7, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Darnestown Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Darnestown, Md.</b>	
23. BURIAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 10 1957</b> 24b. REGISTRAR'S SIGNATURE <i>James Levey</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 10 1957

BUREAU V. 2

Investment in an automobile in collision with a bridge.

Investment in an automobile in collision with a bridge.

Investment in an automobile in collision with a bridge.

Investment in an automobile in collision with a bridge.

Investment in an automobile in collision with a bridge.

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Investment in an automobile in collision with a bridge.

Investment in an automobile in collision with a bridge.

Investment in an automobile in collision with a bridge.

RECEIVED

9807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b> <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Naylor</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges Gen. Hospital</b>				d. STREET ADDRESS <b>Box C 87</b>			
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Pinkney</b> Last <b>Pinkney</b>				4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-6-92</b>	9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>Richard Skinner</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Spence</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Joseph Pinkney Box 87 Naylor, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive Heart Failure 3 weeks</b> DUE TO (b) <b>Hypertensive Heart Disease 1 year</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gen. Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8-24</b> , 19 <b>57</b> , to <b>9-11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-11</b> , 19 <b>57</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Samuel J. Sugar</b> M.D.				ADDRESS (Street, city or town, state) <b>4300 KAYWOOD Dr</b>		DATE SIGNED <b>9/12/57</b>	
PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR MD</b>				ADDRESS <b>MT RAINIER, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-14-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brooks Church</b>		22d. LOCATION (City, town, or county) (State) <b>Naylor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Myrtle R. Rollins</b>				ADDRESS <b>4339 Hunt Pl. N.E. 19, D.C.</b>		24a. REGISTRY SIGNATURE <b>SEP 11 1957</b>	
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

# CERTIFICATE OF DEATH

ARKLAND STATE DEPARTMENT OF HEALTH—BIRMINGHAM, ALA.

NAME OF DECEASED <i>James Earl Ray</i>		SEX <i>Male</i>		AGE <i>35</i>		DATE OF BIRTH <i>May 19, 1928</i>	
PLACE OF BIRTH <i>London, England</i>		OCCUPATION <i>Writer</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>	
DATE OF DEATH <i>May 14, 1968</i>		PLACE OF DEATH <i>London, England</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF DECEASED <i>James Earl Ray</i>		SIGNATURE OF WITNESS <i>James Earl Ray</i>		SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		SIGNATURE OF CLERK <i>James Earl Ray</i>	
DATE OF SIGNATURE <i>May 14, 1968</i>		DATE OF SIGNATURE <i>May 14, 1968</i>		DATE OF SIGNATURE <i>May 14, 1968</i>		DATE OF SIGNATURE <i>May 14, 1968</i>	

BUREAU V. 5

SEP 17 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9808 Items 7,9 Film 0221 10-10-57 et

### CERTIFICATE OF DEATH

09824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>85 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Proctor</b> Last <b>Proctor</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>30</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 June 1904</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Edward B Simonds</b>				14. MOTHER'S MAIDEN NAME <b>Delia E. Laster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>C. Oliver Proctor</b> Address <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>175X CARCINOMATOSIS</b> DUE TO (b) <b>CARCINOMA of Ovary</b> DUE TO (c) <b>lying cause lost.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>9/1, 1955</b> to <b>9/30, 1957</b> , that I last saw the deceased alive on <b>9/30, 1957</b> , and that death occurred at <b>5:30 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. Deitz</b>		ADDRESS (Street, city or town, state) <b>Hyattsville, Md.</b>		DATE SIGNED <b>9-30-57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. A. Deitz</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/2/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Maryland.</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 4 '57</b>	24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>				

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09825

9809

CERTIFICATE OF DEATH

Item 7. Film G220. 9/26/57 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mt. Rainier</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		d. STREET ADDRESS <b>3803 35th St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>W</b> Last <b>Richards</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>18</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-18-77</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture Dept Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Ind -</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Benjamin Richards</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Isabelle Underwood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Sarah E. Nichols</b>		Address <b>Washington D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Seminoma of the Testicle</b> DUE TO (c) <b>178x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>16 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 31</b> , 19 <b>57</b> , to <b>Sept 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept 18</b> , 19 <b>57</b> , and that death occurred at <b>10:25 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>4300 Raymond Drive, 9/19/57</b>	
ACTUAL SIGNATURE <b>Samuel J. Sugar</b> M.D.		DATE SIGNED <b>MT. RAINIER, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Samuel J. Sugar, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/21/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 23 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
CERTIFICATE OF DEATH

PLACE OF BIRTH		PLACE OF DEATH	
BOSTON		BOSTON	
DATE OF BIRTH		DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
AGE		AGE	
10		10	
SEX		SEX	
MALE		MALE	
RACE		RACE	
WHITE		WHITE	
MARRIAGE		MARRIAGE	
MARRIED		MARRIED	
DURATION OF MARRIAGE		DURATION OF MARRIAGE	
10		10	
CAUSE OF DEATH		CAUSE OF DEATH	
DIPHTHERIA		DIPHTHERIA	
PERIOD OF ILLNESS		PERIOD OF ILLNESS	
10		10	
PLACE OF INTERMENT		PLACE OF INTERMENT	
BOSTON		BOSTON	
DATE OF INTERMENT		DATE OF INTERMENT	
JAN 1 1900		JAN 1 1900	
NAME OF MINISTER		NAME OF MINISTER	
J. J. J. J.		J. J. J. J.	
NAME OF CLERGYMAN		NAME OF CLERGYMAN	
J. J. J. J.		J. J. J. J.	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
J. J. J. J.		J. J. J. J.	
NAME OF BURIAL PLACE		NAME OF BURIAL PLACE	
J. J. J. J.		J. J. J. J.	
NAME OF CEMETERY		NAME OF CEMETERY	
J. J. J. J.		J. J. J. J.	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
J. J. J. J.		J. J. J. J.	
NAME OF BURIAL PLACE		NAME OF BURIAL PLACE	
J. J. J. J.		J. J. J. J.	
NAME OF CEMETERY		NAME OF CEMETERY	
J. J. J. J.		J. J. J. J.	

RECEIVED  
SEP 23 1957  
BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithland</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4450 Whitehall Street</b>		d. STREET ADDRESS <b>17004 Griep Street</b>	
3. NAME OF DECEASED (Type or print) <b>Bessie</b> First <b>E.</b> Middle <b>RIEGER</b> Last		4. DATE OF DEATH <b>Sept. 16, 1957</b> (Month Day Year) <b>August 23, 1878</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/23/78</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>New York City, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. of A.</b>	
13. FATHER'S NAME <b>Albert Sylvester Frazier</b>		14. MOTHER'S MAIDEN NAME <b>Hanna Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs. R. S. Tryon, 7004 Griep St., Pleasant.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>—</b> (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis, rheumatoid, severe</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. — 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 25, 1956</b> to <b>Sept. 16, 1957</b> , that I last saw the deceased alive on <b>Sept. 15, 1957</b> , and that death occurred at <b>12:35 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walcutt W. Gibson</b> M.D.		ADDRESS (Street, city or town, state) <b>2412 Minnesota Avenue, S.E.</b>	
PHYSICIAN'S NAME (Type) <b>Walcutt W. Gibson</b>		DATE SIGNED <b>Washington 20, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>SEP 17 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Div. No.

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar		12. Date of Registration	
F. M. W.		M		W		1910		1957		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]		1957	
13. Occupation		14. Education		15. Marital Status		16. Date of Marriage		17. Date of Last Examination		18. Date of Last Medical Advice		19. Date of Last Hospital Admission		20. Date of Last Discharge		21. Date of Last Death Certificate		22. Date of Last Burial		23. Date of Last Cremation		24. Date of Last Interment	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

RECEIVED  
SEP 17 1957  
BUREAU V. S.

09827

9810

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. LENGTH OF STAY IN 1b <b>adm. 7-19-57</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>		d. STREET ADDRESS <b>KENESAW AVE. 16th &amp; Irving Sts. N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>BESSIE</b> First <b>CARTER</b> Middle <b>RILEY</b> Last		4. DATE OF DEATH <b>September 26</b> 1957	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-1867</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR <b>4</b> Months <b>20</b> Days <b>-</b> Hours <b>-</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN GRAYSON CARTER</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN FITZ HUGH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, Laurel Sanitarium</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VENTRICULAR Fibrillation</b> <b>422.1</b> DUE TO <b>arteriosclerotic cardio-vascular disease many years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO <b>-</b> (c) <b>-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic brain syndrome associated with cerebral arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-19-</b> 1957, to <b>9-26-</b> 1957, that I last saw the deceased alive on <b>9-25-</b> 1957, and that death occurred at <b>1:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Erika P. Kraemer</b>		DATE SIGNED <b>Laurel 9-26-57</b>	
PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>		<b>LAUREL SANITARIUM, LAUREL M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 28/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyson, Co., 1300 N ST. N.W., D.C.</b>		24a. REC'D BY REGISTRAR <b>SEP 27 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Rehail</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 27 1957

SEP 27 1957

9811

CERTIFICATE OF DEATH

09828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>				c. LENGTH OF STAY IN 1b <u>26 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Inwood Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CARRIE</u> First <u>—</u> Middle <u>—</u> Last <u>Ringold</u>				4. DATE OF DEATH <u>Sept. 4</u> 19 <u>57</u> Month <u>4</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 1, 1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>JACK HARRIS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CHARLES H. WASHINGTON - Bladensburg</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEUKEMIA</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC Nephritis with Hypertension</u> DUE TO (c) <u>CHRONIC VASCULAR DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>4-5 YRS</u> <u>8-10 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour <u>9.31</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat. while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>MARCH 5, 1957</u> , to <u>Sept. 4, 1957</u> , that I last saw the deceased alive on <u>Sept. 2, 1957</u> , and that death occurred at <u>430a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Spiller</u>				ADDRESS (Street, city or town, state) <u>4506 R. I. Ave. Brentwood Md</u> DATE SIGNED <u>9-4-57</u>			
PHYSICIAN'S NAME (Type) <u>W. W. Spiller</u>				BRENTWOOD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-7-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) <u>Brentwood Rd. SE. DC</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henny S. Washington</u> ADDRESS <u>467 N 2nd NW</u>				24a. REC'D BY REGISTRAR <u>SEP 9</u>		24b. REGISTRAR'S SIGNATURE <u>1957 A. H. Sedw...</u>	

CERTIFICATE OF DEATH

1957

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The text is faint and mostly illegible.

BUREAU V. S.

SEP 9 1957

RECEIVED



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9848

CERTIFICATE OF DEATH

09829

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf Rural Lx1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Joseph First Marvin Middle Robey Last				4. DATE OF DEATH Sept. 5 Day 1957 Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Charles Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Robey				14. MOTHER'S MAIDEN NAME Mary Emma Downs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 214-36-3817		17. INFORMANT Mrs. Gladys Robey, Waldorf, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Apoplexy 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Cardio Vascular Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1940 to Sept 5, 1957, that I last saw the deceased alive on June 4, 1957, and that death occurred at Waldorf, Md., from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				DATE SIGNED			
PHYSICIAN'S NAME (Type) GEORGE S. JOHNSON, M.D.				ADDRESS (Street, city or town, state) Waldorf, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Pauls		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
Hunt Funeral Home, Waldorf, Md.				DATE SEP 10 '57		[Signature]	

CERTIFICATE OF DEATH

1. Name of Deceased: *Joseph Morris Robert*  
2. Date of Birth: *Feb 11 1907*  
3. Sex: *M*  
4. Race: *W*  
5. Cause of Death: *Myocardial Infarction*  
6. Date of Death: *Feb 23 1957*  
7. Place of Death: *Home*  
8. Signature of Physician: *Dr. J. H. Brown*  
9. Signature of Registrar: *J. H. Brown*

BUREAU V. S.

SEP 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9812

CERTIFICATE OF DEATH

Reg. Dist. No. 11074

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Bowie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges</u>				d. STREET ADDRESS <u>1109 - Chester Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Savoy</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-10-57</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u>		IF UNDER 24 HRS Hours <u>1</u> Min <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Thomas LeRoy Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Mary Delores Savoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mother</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (2050 gms. 16 inches)</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 10</u> , 19 <u>57</u> , to <u>Sept 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>57</u> , and that death occurred at <u>9:40</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John W. Perkins</u> M.D. <u>5301 Hamilton St., Hyattsville</u> <u>9/11/57</u> PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince George's General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Cheverly, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Penn, Jr., Administrator.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>OCT 16 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

2077161XV3

CERTIFICATE OF DEATH

DEATH OF VARIOUS (1) Name of deceased (2) Sex (3) Age (4) Race (5) Date of birth (6) Date of death (7) Place of death (8) Cause of death (9) Manner of death (10) Signature of physician (11) Signature of registrar (12) Date of registration		(13) Name of informant (14) Address of informant (15) Signature of informant (16) Date of completion
(17) Name of informant (18) Address of informant (19) Signature of informant (20) Date of completion		(21) Name of informant (22) Address of informant (23) Signature of informant (24) Date of completion
(25) Name of informant (26) Address of informant (27) Signature of informant (28) Date of completion		(29) Name of informant (30) Address of informant (31) Signature of informant (32) Date of completion
(33) Name of informant (34) Address of informant (35) Signature of informant (36) Date of completion		(37) Name of informant (38) Address of informant (39) Signature of informant (40) Date of completion
(41) Name of informant (42) Address of informant (43) Signature of informant (44) Date of completion		(45) Name of informant (46) Address of informant (47) Signature of informant (48) Date of completion
(49) Name of informant (50) Address of informant (51) Signature of informant (52) Date of completion		(53) Name of informant (54) Address of informant (55) Signature of informant (56) Date of completion
(57) Name of informant (58) Address of informant (59) Signature of informant (60) Date of completion		(61) Name of informant (62) Address of informant (63) Signature of informant (64) Date of completion
(65) Name of informant (66) Address of informant (67) Signature of informant (68) Date of completion		(69) Name of informant (70) Address of informant (71) Signature of informant (72) Date of completion
(73) Name of informant (74) Address of informant (75) Signature of informant (76) Date of completion		(77) Name of informant (78) Address of informant (79) Signature of informant (80) Date of completion
(81) Name of informant (82) Address of informant (83) Signature of informant (84) Date of completion		(85) Name of informant (86) Address of informant (87) Signature of informant (88) Date of completion
(89) Name of informant (90) Address of informant (91) Signature of informant (92) Date of completion		(93) Name of informant (94) Address of informant (95) Signature of informant (96) Date of completion
(97) Name of informant (98) Address of informant (99) Signature of informant (100) Date of completion		(101) Name of informant (102) Address of informant (103) Signature of informant (104) Date of completion

BUREAU V. S.

OCT 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9813

CERTIFICATE OF DEATH

11077  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 hours</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>33 Bladensburg, Maryland</b> d. STREET ADDRESS <b>Box 102</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Sharpe</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>13</b> Year <b>19 57</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 13 1957</b>		
9. AGE (In years lost birthday) <b>2 yrs.</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>13</b> Hours <b>57</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME <b>Elijah Washington</b>				14. MOTHER'S MAIDEN NAME <b>Geraldine Sharpe</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>mother - as above</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (1050 gms. 13 inches)</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 13, 1957</b> to <b>Sept 13, 1957</b> that I last saw the deceased alive on <b>Sept 13, 1957</b> and that death occurred at <b>2:30 AM</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>John W. Perkins</b>				ADDRESS (Street, city or town, state) <b>5301 Hawthorn St. Baltimore</b>				
PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>				DATE SIGNED <b>9/14/57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>10/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Cheverly, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harold W. Perry, Jr. Administrator</b>				24a. REC'D BY REGISTRAR <b>DATE OCT 16 57</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077202 XVI



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9849

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges'</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>				c. LENGTH OF STAY IN 1b <b>10 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>17501 Marlboro Pike, S.E.</b>				d. STREET ADDRESS <b>17501 Marlboro Pike, S.E.</b>			
3. NAME OF DECEASED (Type or print) First <b>Flossie</b> Middle <b>May</b> Last <b>Simmons</b>				4. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>David Hurt</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Helen Stamp- same as above.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial decompensation</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease</b> DUE TO (c) <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic nonspecific colitis 6mo</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>"Natural" Causes</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>---</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>				20g. (County) <b>---</b>		20h. (State) <b>---</b>	
21. I certify that I attended the deceased from <b>Aug 22, 1957</b> , to <b>Sept 17, 1957</b> , that I last saw the deceased alive on <b>Aug 16, 1957</b> , and that death occurred at <b>8 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul C VanNatta</b> M.D.				ADDRESS (Street, city or town, state) <b>5440 Silver Hill Rd SE Washington DC</b>			
PHYSICIAN'S NAME (Type) <b>PAUL C VANNATTA MD</b>				DATE SIGNED <b>9/17/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Addison's Chapel Cem:</b>		22d. LOCATION (City, town, or county) (State) <b>Seat Pleasant, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>				ADDRESS <b>Upper</b>		24. REC'D BY REGISTRAR <b>SEP 20 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>			

# CERTIFICATE OF DEATH

9250

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. DATE OF MARRIAGE [Faint text]</p>	
<p>9. NAME OF SPOUSE [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. CAUSE OF DEATH [Faint text]</p>	
<p>13. MEDICAL HISTORY [Faint text]</p>		<p>14. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>15. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>16. OFFICIAL SEAL [Faint text]</p>	

BUREAU V. S.

SEP 25 1957

RECEIVED

9814

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>1 Hr 20Min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges Md</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> d. STREET ADDRESS <b>Rt 2 Box 302 A</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b> First Middle Last <b>Simms</b>				4. DATE OF DEATH Month Day Year <b>Sept 4- 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 4, 57</b>	
9. AGE (In years last birthday) yrs. <b>1</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James M. Simms</b>				14. MOTHER'S MAIDEN NAME <b>Virginia A. Locks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother - as above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal Atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity (weight 700 gms. length 12 inches)</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9/4/ 19 57</b> , to <b>9/4/ 19 57</b> , that I last saw the deceased alive on <b>9/4/ 19 57</b> , and that death occurred at <b>8:40P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state). DATE SIGNED <b>John W. Perkins</b> M.D. <b>5301 Hamilton Rd., Hyattsville, Md 9/6/57</b>							
ACTUAL SIGNATURE <b>John W. Perkins</b>							
PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Cremation</b>		<b>Sept 19 57</b>		<b>Prince Georges General Hospital</b>		<b>Cheverly Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Perkins</b>				ADDRESS <b>Adams</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 18 57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>			

2077289XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 18 1957

RECEIVED



9815

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherethly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George</u>				d. STREET ADDRESS <u>4408-Garrison St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A</u> Last <u>Stanton</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>typotype</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>John</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Benjamin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Claude Stanton-6803-Fairfax Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/9/57</u> , 19 <u>57</u> , to <u>9/11/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/11</u> , 19 <u>57</u> , and that death occurred at <u>9:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederick E. Mueser</u> M.D.				ADDRESS (Street, city or town, state) <u>2409 Van Ness St N.W. Washington, D.C.</u> DATE SIGNED <u>9/11/57</u>			
PHYSICIAN'S NAME (Type) <u>London Hills, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Rd. Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO</u> ADDRESS <u>3072 M St N.W.</u>				24a. REC'D BY REGISTRAR <u>SEP 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09833

9816

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b> <b>x2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>7805 Halleck Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Bonnie</b> Middle <b>Stottlemire</b> Last <b>Stottlemire</b>			4. DATE OF DEATH Month <b>September</b> Day <b>26</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/7/53</b>		9. AGE (In years lost birthday) <b>4</b> yrs. IF UNDER 1 YEAR: Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Lloyd Stottlemire</b>			14. MOTHER'S MAIDEN NAME <b>Edith Life</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edith Life</b> Address <b>7805 Halleck St. Dist. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>292.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pancytopenia</b> DUE TO (c) <b>Aplastic Anemia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>1 month</b> <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p. <b>19</b> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/29, 1957</b> , to <b>9/26, 1957</b> , that I last saw the deceased alive on <b>9/26, 1957</b> , and that death occurred at <b>6:05 P. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>John T. Ryan</b>			ADDRESS (Street, city or town, state) <b>5241 St. Barnabas Rd</b> DATE SIGNED <b>9/27/57</b>		
PHYSICIAN'S NAME (Type) <b>John T. Ryan</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-30-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Natl. Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chamberlaine</b>			ADDRESS <b>517-11th St. S.E.</b>		24a. REC'D BY REGISTRAR <b>Oct 1 '57</b>
			24b. REGISTRAR'S SIGNATURE <b>W. W. Chamberlaine</b>		



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09834

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges'</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Prince Georges'</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>15 Min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Upper Marlboro X/</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges' General Hospital</u>				d. STREET ADDRESS <u>Rt. #2, Box 98</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Franklin</u> Middle <u>A.</u> Last <u>Sweeney</u>				<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>9,</u> Year <u>1957.</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Nov. 8, 1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Empld Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Comm.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Greenberry Sweeney</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs. Lorraine Virgin-</u>			
Address same as above.							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of the base of the skull</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>car</u> <u>Driver of an automobile that was struck by another</u>					
20c. TIME OF INJURY Hour <u>9:20</u> <u>AM</u> <u>9/9/19</u> 57		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route # 301 Upper Marlboro P. G. Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>		EXAMINER'S NAME (Type) <u>James I. Boyd, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>9/10/57:</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Forestville, Maryland.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 16 '57</u>			
ADDRESS <u>Upper Marlboro, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Overhaugh</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

SEP 16 1957

RECEIVED

9818

## CERTIFICATE OF DEATH

Reg. Dist. No. 09835

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md 15</b>			
d. STREET ADDRESS <b>7112 Annapolis Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Sweeney</b> Last				4. DATE OF DEATH Month <b>Sept</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB 9<sup>th</sup> 1905</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT LESTER SWEENEY</b>				14. MOTHER'S MAIDEN NAME <b>MARY MARGARET SWEENEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MRS. RUTH SWEENEY</b> Address <b>7112-ANAPOLIS RD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lower leg with metastases</b> <b>140X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1 Jul</b> , 1957, to <b>4 Sept</b> , 1957, that I last saw the deceased alive on <b>3 Sept</b> , 1957, and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, State) <b>4814-71st Ave. Lanham Heights</b> DATE SIGNED <b>4 Sept 57</b>							
ACTUAL SIGNATURE <b>Thomas J. Maloney</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. T. Maloney</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-8-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		22d. LOCATION (City, town, or county) (State) <b>WASH. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Houston</b> ADDRESS <b>3831-GA Ave N.W.</b>				24a. REC'D BY REGISTRAR <b>SEP 9 '57</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1912	
5. PLACE OF BIRTH Boston, Mass.		6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF DEATH 1957	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF CLERK [Signature]		15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF DECEASED [Signature]	
17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF BURIAL OFFICER [Signature]		19. SIGNATURE OF CHURCH OFFICER [Signature]		20. SIGNATURE OF FUNERAL HOME [Signature]	
21. SIGNATURE OF CORONER [Signature]		22. SIGNATURE OF JURY [Signature]		23. SIGNATURE OF JUDGE [Signature]		24. SIGNATURE OF DISTRICT ATTORNEY [Signature]	
25. SIGNATURE OF STATE ATTORNEY [Signature]		26. SIGNATURE OF U.S. ATTORNEY [Signature]		27. SIGNATURE OF U.S. DISTRICT JUDGE [Signature]		28. SIGNATURE OF U.S. SUPREME COURT [Signature]	
29. SIGNATURE OF U.S. SUPREME COURT [Signature]		30. SIGNATURE OF U.S. SUPREME COURT [Signature]		31. SIGNATURE OF U.S. SUPREME COURT [Signature]		32. SIGNATURE OF U.S. SUPREME COURT [Signature]	
33. SIGNATURE OF U.S. SUPREME COURT [Signature]		34. SIGNATURE OF U.S. SUPREME COURT [Signature]		35. SIGNATURE OF U.S. SUPREME COURT [Signature]		36. SIGNATURE OF U.S. SUPREME COURT [Signature]	
37. SIGNATURE OF U.S. SUPREME COURT [Signature]		38. SIGNATURE OF U.S. SUPREME COURT [Signature]		39. SIGNATURE OF U.S. SUPREME COURT [Signature]		40. SIGNATURE OF U.S. SUPREME COURT [Signature]	
41. SIGNATURE OF U.S. SUPREME COURT [Signature]		42. SIGNATURE OF U.S. SUPREME COURT [Signature]		43. SIGNATURE OF U.S. SUPREME COURT [Signature]		44. SIGNATURE OF U.S. SUPREME COURT [Signature]	
45. SIGNATURE OF U.S. SUPREME COURT [Signature]		46. SIGNATURE OF U.S. SUPREME COURT [Signature]		47. SIGNATURE OF U.S. SUPREME COURT [Signature]		48. SIGNATURE OF U.S. SUPREME COURT [Signature]	
49. SIGNATURE OF U.S. SUPREME COURT [Signature]		50. SIGNATURE OF U.S. SUPREME COURT [Signature]		51. SIGNATURE OF U.S. SUPREME COURT [Signature]		52. SIGNATURE OF U.S. SUPREME COURT [Signature]	
53. SIGNATURE OF U.S. SUPREME COURT [Signature]		54. SIGNATURE OF U.S. SUPREME COURT [Signature]		55. SIGNATURE OF U.S. SUPREME COURT [Signature]		56. SIGNATURE OF U.S. SUPREME COURT [Signature]	
57. SIGNATURE OF U.S. SUPREME COURT [Signature]		58. SIGNATURE OF U.S. SUPREME COURT [Signature]		59. SIGNATURE OF U.S. SUPREME COURT [Signature]		60. SIGNATURE OF U.S. SUPREME COURT [Signature]	
61. SIGNATURE OF U.S. SUPREME COURT [Signature]		62. SIGNATURE OF U.S. SUPREME COURT [Signature]		63. SIGNATURE OF U.S. SUPREME COURT [Signature]		64. SIGNATURE OF U.S. SUPREME COURT [Signature]	
65. SIGNATURE OF U.S. SUPREME COURT [Signature]		66. SIGNATURE OF U.S. SUPREME COURT [Signature]		67. SIGNATURE OF U.S. SUPREME COURT [Signature]		68. SIGNATURE OF U.S. SUPREME COURT [Signature]	
69. SIGNATURE OF U.S. SUPREME COURT [Signature]		70. SIGNATURE OF U.S. SUPREME COURT [Signature]		71. SIGNATURE OF U.S. SUPREME COURT [Signature]		72. SIGNATURE OF U.S. SUPREME COURT [Signature]	
73. SIGNATURE OF U.S. SUPREME COURT [Signature]		74. SIGNATURE OF U.S. SUPREME COURT [Signature]		75. SIGNATURE OF U.S. SUPREME COURT [Signature]		76. SIGNATURE OF U.S. SUPREME COURT [Signature]	
77. SIGNATURE OF U.S. SUPREME COURT [Signature]		78. SIGNATURE OF U.S. SUPREME COURT [Signature]		79. SIGNATURE OF U.S. SUPREME COURT [Signature]		80. SIGNATURE OF U.S. SUPREME COURT [Signature]	
81. SIGNATURE OF U.S. SUPREME COURT [Signature]		82. SIGNATURE OF U.S. SUPREME COURT [Signature]		83. SIGNATURE OF U.S. SUPREME COURT [Signature]		84. SIGNATURE OF U.S. SUPREME COURT [Signature]	
85. SIGNATURE OF U.S. SUPREME COURT [Signature]		86. SIGNATURE OF U.S. SUPREME COURT [Signature]		87. SIGNATURE OF U.S. SUPREME COURT [Signature]		88. SIGNATURE OF U.S. SUPREME COURT [Signature]	
89. SIGNATURE OF U.S. SUPREME COURT [Signature]		90. SIGNATURE OF U.S. SUPREME COURT [Signature]		91. SIGNATURE OF U.S. SUPREME COURT [Signature]		92. SIGNATURE OF U.S. SUPREME COURT [Signature]	
93. SIGNATURE OF U.S. SUPREME COURT [Signature]		94. SIGNATURE OF U.S. SUPREME COURT [Signature]		95. SIGNATURE OF U.S. SUPREME COURT [Signature]		96. SIGNATURE OF U.S. SUPREME COURT [Signature]	
97. SIGNATURE OF U.S. SUPREME COURT [Signature]		98. SIGNATURE OF U.S. SUPREME COURT [Signature]		99. SIGNATURE OF U.S. SUPREME COURT [Signature]		100. SIGNATURE OF U.S. SUPREME COURT [Signature]	

BUREAU V. S.

SEP 9 1957

RECEIVED

9819

## CERTIFICATE OF DEATH

09836

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Oakfest</b>	
f. STREET ADDRESS <b>Rt. 2 Box 140</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>3 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 Sept. 1957</b>
9. AGE (In years last birthday) <b>24</b>		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>24</b> Min. <b>24</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Taylor, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Nichols</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>mother - as above</b>	
17. INFORMANT <b>as above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776x PREMATUREITY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>776x</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 3, 1957</b> to <b>Sept 3, 1957</b> that I last saw the deceased alive on <b>Sept 3, 1957</b> , and that death occurred at <b>4:10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>320 Montgomery Laurel MD</b> DATE SIGNED <b>9/4/57</b>			
ACTUAL SIGNATURE <b>Frank L. Weaver, Jr.</b>		M.D. <b>320 Montgomery Laurel MD</b>	
PHYSICIAN'S NAME (Type) <b>Frank L. Weaver, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>Sept 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince Georges Gen Hosp</b>	22d. LOCATION (City, town, or county) (State) <b>Cherry Hill</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Adams</b>		24a. REC'D BY REGISTRAR <b>SEP 18 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>Adams</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Page One of Two

<p>NAME OF DECEASED                  [REDACTED]</p>		<p>DATE OF BIRTH                  [REDACTED]</p>	
<p>SEX                  [REDACTED]</p>		<p>RACE                  [REDACTED]</p>	
<p>DATE OF DEATH                  [REDACTED]</p>		<p>PLACE OF DEATH                  [REDACTED]</p>	
<p>CAUSE OF DEATH                  [REDACTED]</p>		<p>MANNER OF DEATH                  [REDACTED]</p>	
<p>EDUCATION                  [REDACTED]</p>		<p>OCCUPATION                  [REDACTED]</p>	
<p>RELIGION                  [REDACTED]</p>		<p>US BIRTH                  [REDACTED]</p>	
<p>DATE OF DEATH                  [REDACTED]</p>		<p>PLACE OF DEATH                  [REDACTED]</p>	
<p>CAUSE OF DEATH                  [REDACTED]</p>		<p>MANNER OF DEATH                  [REDACTED]</p>	
<p>EDUCATION                  [REDACTED]</p>		<p>OCCUPATION                  [REDACTED]</p>	
<p>RELIGION                  [REDACTED]</p>		<p>US BIRTH                  [REDACTED]</p>	

RECEIVED  
 SEP 18 1957  
 BUREAU V. 1



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9820 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09837

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>24 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York</b> <span style="float: right;">69X-3</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>248 W. 133rd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ella Francis Taylor</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>4th,</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5-31-09</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.c.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Ella F. Gause</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mary C. Dublin, 4400 Douglas St., N.E. Wash. D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral compression</b> <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Subdural Hemorrhage</b> (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Riding as a passenger in an automobile in collision with another.</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>6:30 AM 9-3- 19 57</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Landover, Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 5, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Paynes</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Stewart</b>				ADDRESS <b>30 H Street, N.E.</b>		24a. REC'D BY REGISTRAR <b>SEP 9 '57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 9 1957

BUREAU V. E.

Highway

0-30 0-30

Driving on a highway in an automobile in collision with another

Suburban Garage

Commercial Corporation

Miss Y. Davis

William Taylor

Washington, D.C.

Female

0-30

Taylor

Prison

0-30

Sept. 1957

24 hours

Overnight

New York

Prince George

New York

1957 STATE  
HEALTH DEPT

9821

## CERTIFICATE OF DEATH

Reg. Dist. No.

09838745

1. PLACE OF DEATH a. COUNTY <i>PR Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>same</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4705 - Longfellow st</i>		d. STREET ADDRESS <i>4705 Longfellow st</i>	
3. NAME OF DECEASED (Type or print) <i>ANNIE</i> First <i>LOUISE</i> Middle <i>THOMPSON</i> Last		4. DATE OF DEATH <i>Sept 23</i> 19 <i>57</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 23 - 1897</i> 19 <i>78</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Milliner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Textile</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Corr Rutherford</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Gertrude Kacke</i> Address <i>—</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Pulmonary Congestion</i> <i>580X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Hepatic Failure</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>			
21. I certify that I attended the deceased from <i>9-21</i> , 19 <i>57</i> , to <i>9-23</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>9-23</i> , 19 <i>57</i> , and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W L Etienne</i>		DATE SIGNED <i>9-23-57</i>	
PHYSICIAN'S NAME (Type) <i>W L ETIENNE</i>		ADDRESS (Street, city or town, state) <i>4713 - Berwyn Rd College Park, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 25, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Bladensburg, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville Md.</i>		24a. REC'D BY REGISTRAR <i>—</i> DATE <i>SEP 25 1957</i>	24b. REGISTRAR'S SIGNATURE <i>James Harvey</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 25 1957

RECEIVED

9850

## CERTIFICATE OF DEATH

Reg. Dist. No.

0983442

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SWITLAND</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SWITLAND</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>201-SWANN RD SE.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mabel E. Thompson</i>				4. DATE OF DEATH <i>Sept. 18 1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAR. 25-1886</i>	
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
11. BIRTHPLACE (State or foreign country) <i>England</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>William Ellis</i>				14. MOTHER'S MAIDEN NAME <i>Agnes Packham</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Eileen T. Gardner</i>				Address <i>301-SWANN RD SE.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> 449X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive cardiovascular disease</i> DUE TO (c) <i>10 yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>February, 1952</i> , to <i>Sept. 18, 1957</i> , that I last saw the deceased alive on <i>Sept 10, 1957</i> , and that death occurred at <i>7:30 P. M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>1625 Mass. Ave. NW. Wash. D.C.</i>				DATE SIGNED <i>Sept 18, 1957</i>			
ACTUAL SIGNATURE <i>Cornelius P. Frey</i>				M.D. <i>—</i>			
PHYSICIAN'S NAME (Type) <i>CORNELIUS P. FREY</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 20-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Int almet</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros</i>				ADDRESS <i>1661-good Hope Rd</i>		24a. REC'D BY REGISTRAR <i>—</i>	
24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>				DATE <i>SEP 19 1957</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, illegible]		SEX [Faint text, illegible]		AGE [Faint text, illegible]	
DATE OF BIRTH [Faint text, illegible]		PLACE OF BIRTH [Faint text, illegible]		DATE OF DEATH [Faint text, illegible]	
TIME OF DEATH [Faint text, illegible]		PLACE OF DEATH [Faint text, illegible]		CAUSE OF DEATH [Faint text, illegible]	
MANNER OF DEATH [Faint text, illegible]		MEDICAL HISTORY [Faint text, illegible]		SOCIAL HISTORY [Faint text, illegible]	
OCCUPATION [Faint text, illegible]		EDUCATION [Faint text, illegible]		RELIGION [Faint text, illegible]	
MARITAL STATUS [Faint text, illegible]		PREVIOUS MARRIAGES [Faint text, illegible]		PREVIOUS DEATHS [Faint text, illegible]	
SIGNATURE OF DECEASED [Faint text, illegible]		SIGNATURE OF WITNESS [Faint text, illegible]		SIGNATURE OF PHYSICIAN [Faint text, illegible]	
SIGNATURE OF CORONER [Faint text, illegible]		SIGNATURE OF JURY [Faint text, illegible]		SIGNATURE OF JUDGE [Faint text, illegible]	

BUREAU V. 1

SEP 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3a should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9851  
CERTIFICATE OF DEATH

09840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANDOVER KNOLLS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6505 - OTIS ST.</u>		d. STREET ADDRESS <u>1405 E. CAPITAL ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAULINE A. THOMPSON</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 26 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 6, 1906</u>
9. AGE (In years last birthday) yrs. <u>51</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES STROBEL</u>		14. MOTHER'S MAIDEN NAME <u>Hennietta Kaus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ALBERT T. THOMPSON</u>		Address <u>6614 POWHATAN ST. E. RIVERDALE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>10 years +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-28, 1947</u> , to <u>9-26, 1957</u> , that I last saw the deceased alive on <u>9-24, 1957</u> , and that death occurred at <u>8</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John H. Hazard M.D. 3409 Wisconsin Ave. N. W.</u> PHYSICIAN'S NAME (Type) <u>John H. Hazard</u> <u>Wash., D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Buried</u>		<u>9-30-57</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Washington Nat.</u>		<u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees</u>		ADDRESS <u>Lees Bros - Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>SEP 27 57</u>		24b. REGISTRAR'S SIGNATURE <u>Quail</u>	

up coroner notified 9/27/57

BUREAU V. S.

SEP 27 1957

RECEIVED

9822

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b <b>17 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GEN. HOSP.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4222 KENNEDY ST.</b>			
				f. STREET ADDRESS <b>HYATTSVILLE</b>			
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Edward</b> Last <b>THORPE</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>6</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 29th, 1909</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic (Electrical)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. Sub. Sen. Comm.</b>		11. BIRTHPLACE (State or foreign country) <b>Laurel, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Frank B. Thorpe</b>				14. MOTHER'S MAIDEN NAME <b>Maude Eva Brady</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give year or dates of service) <b>WW 11</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Grace M. Thorpe, 4222 Kennedy St. Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of lungs</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>9</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9/5</b> , 19 <b>57</b> , to <b>9/6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/6</b> , 19 <b>57</b> , and that death occurred at <b>4/10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William B. Hagan</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>3303 Perry St. Mt. Airier, Md. 9/6/57</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM B. HAGAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/9/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Pr. Geo. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 11 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF CHIEF OF BUREAU	

BUREAU V. S.

SEP 11 1957

RECEIVED



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9823

Item 14 FilmG220 9-17-57 et

09842

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>5534 Bass Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Threats</b> First Middle Last 4. DATE OF DEATH <b>Sept. 3, 19 57</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Colored</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>7-23-13</b> 9. AGE (In years last birthday) <b>34</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b> 11. BIRTHPLACE (State or foreign country) <b>Arkansas</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Leon Threats</b> 14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <input type="checkbox"/>		Address <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 816X DUE TO Conditions, if any, which gave rise to the immediate cause (b) <b>Crushed chest, abdomen and pelvis</b> (c) <b>Automobile accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Operator of an automobile in collision with a bus.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>6.30</b> Hour <b>XX</b> p. m. <b>9-3-57</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b> 20f. (City or town) (County) (State) <b>Landover Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b> EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>September 4, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-13-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Johnson &amp; Jenkins</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 11 '57</b> 24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 11 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9824

CERTIFICATE OF DEATH

09843

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>				c. LENGTH OF STAY IN 1b <b>6 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Trussell</b> Last <b>Trussell</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-29-90</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>57</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Loudon County, Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>B enjamin F. Mills</b>				14. MOTHER'S MAIDEN NAME <b>Emma Holiday</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Willie Trussell Husband</b>		Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> <b>199.9</b> DUE TO <b>Carcinoma of the</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Primary not determined</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>9-5, 1957</b> to <b>9-11, 1957</b> that I last saw the deceased alive on <b>9-11, 1957</b> , and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Samuel Schwartzbach</b>				ADDRESS (Street, city or town, state) <b>1726 I. Street, N. W. Wash. D.C.</b>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Sep 14, 1957</b>		<b>Leesburg Cemetery</b>		<b>Leesburg, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walters, 254 Carroll St. NW D.C.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 13 '57</b>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED James George Wilson		AGE 5 Days		SEX Male		RACE White	
DATE OF DEATH January 14, 1957		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
MANNER OF DEATH Natural		CAUSE OF DEATH Sudden		DISEASE OR INJURY None		MEDICAL HISTORY None	
DATE OF BIRTH January 9, 1957		PLACE OF BIRTH Home		CITY Baltimore		COUNTY Baltimore	
MANNER OF BIRTH Normal		CAUSE OF BIRTH None		DISEASE OR INJURY None		MEDICAL HISTORY None	
DATE OF DEATH January 14, 1957		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
MANNER OF DEATH Natural		CAUSE OF DEATH Sudden		DISEASE OR INJURY None		MEDICAL HISTORY None	
DATE OF BIRTH January 9, 1957		PLACE OF BIRTH Home		CITY Baltimore		COUNTY Baltimore	
MANNER OF BIRTH Normal		CAUSE OF BIRTH None		DISEASE OR INJURY None		MEDICAL HISTORY None	

BUREAU V. 3

SEP 13 1957

RECEIVED

9756

## CERTIFICATE OF DEATH

09844

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <b>Prince George County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paint Branch Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Sebastian Voneiff</b>				4. DATE OF DEATH Month Day Year <b>September 3 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 17, 1893</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor (RET) Plumbing, Heating</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Conrad Voneiff</b>				14. MOTHER'S MAIDEN NAME <b>Pauline Toepfer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-18-810</b>		17. INFORMANT Address <b>Mrs. Clara Voneiff, 10204 Proctor St., Silver Spring, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive failure</b> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic heart disease</b> DUE TO (c) <b>20 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lung abscess</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>57</b> , to <b>Sept. 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug. 25</b> , 19 <b>57</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Bennet A. Porter, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>Bennet A. Porter, Jr., M.D. 9301 Colesville Rd. Silver Spring, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner C. Humphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Sept 6 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. Jas. Savere</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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BUREAU V. F.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09845 231

9825

CERTIFICATE OF DEATH

Reg. Dist. No. 440

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT of COLUMBIA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESVERLY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GEN. HOSP.</b>				d. STREET ADDRESS <b>1341 ADAMS ST. N.E.</b>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>E.</b> Last <b>WALTERS</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-90</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>Joseph Walters</b>			
14. MOTHER'S MAIDEN NAME <b>Mary</b> ?????				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Dorothy E Walters</b> Address <b>Washington D.C. 1341 Adams St N.E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcano a of liver a</b> <b>153X</b> DUE TO <b>jaundice</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic from colon (sigmoid)</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>5-6</b> , 1956 to <b>9/7</b> , 1957, that I last saw the deceased alive on <b>9/7</b> , 1957, and that death occurred at <b>2:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George Hageage</b>				ADDRESS (Street, city or town, state) <b>3717 - 38th Ave. Cottage City, Md.</b>			
DATE SIGNED <b>9/7/57</b>							
PHYSICIAN'S NAME (Type) <b>George Hageage</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial Fort Lincoln</b>		<b>September 9th, 1957</b>		<b>Colmar Manor, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>				ADDRESS <b>Washington D.C.</b>			
24a. REC'D BY REGISTRAR <b>Sept. 9-57</b>				24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b> <b>U. S. Health</b>			

# CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

WASHINGTON

DEATH

1911 JUNE 21 A.M.

1911 JUNE 21 A.M.

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DEATH

DEATH

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67

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WASH. D.C.

JOSEPH W. WILSON

WASH. D.C.

WASH. D.C.

67

BUREAU V. S.

SEP 11 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9852

CERTIFICATE OF DEATH

09846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jemple Hills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jemple Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5417 Fisher Road</u>		d. STREET ADDRESS <u>5417 Fisher Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>HEDLEY</u> Middle <u>WELSBY</u> Last <u>WELSBY</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Welsby</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-07-448</u>	
17. INFORMANT <u>Mary V. Welsby</u>		Address <u>5417 Fisher Rd. Jemple Hills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>1957</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>Sept 22, 1957</u> that I last saw the deceased alive on <u>Sept 13, 1957</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward A. Palank</u> M.D.		ADDRESS (Street, city or town, state) <u>5203 S. LOVELL HILL RD. BETHESDA</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD A. PALANK</u>		DATE SIGNED <u>24 SEP 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Will. Chambers Co. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 24 57</u> 24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

BUREAU V. S.

SEP 24 1957

RECEIVED



9826

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>			
f. STREET ADDRESS <u>4108 31<sup>st</sup> Street</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Williams</u> Middle Last				4. DATE OF DEATH <u>September 1 19 57</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25 1896</u>	
9. AGE (In years lost birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman Ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John William Williams</u>				14. MOTHER'S MAIDEN NAME <u>Lucy May Oof</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-22-4346</u>			
17. INFORMANT <u>Bernard F. Williams</u> Address <u>Son</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>Coronary Artery Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 15</u> , 19 <u>57</u> , to <u>1 Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/31/57</u> , 19 <u>57</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Weintraub</u> M.D.				DATE SIGNED <u>9/1/57</u>			
PHYSICIAN'S NAME (Type) <u>William C. Weintraub</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home</u>				24. REC'D BY REGISTRAR <u>Mr. Rainier</u>			
ADDRESS <u>Mr. Rainier</u>				DATE <u>SEP 4 57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

REG. NO. 100

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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BUREAU V. 3

SEP 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09848

Reg. Dist. No.

9827

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deanwood Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>5106 Nye Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Grant Williams</b>	4. DATE OF DEATH <b>Sept. 6 1957</b>	5. SEX <b>Male</b> 6. COLOR OR RACE <b>Colored</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Jan. 6, 1903</b> 9. AGE (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Grant Williams</b>	14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes W.W. 1</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Martha Richardson; same as # 2.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Fractured skull, crushed chest and lacerations, multiple and severe.</b> DUE TO (c) <b>Automobile accident</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>A pedestrian, run over by an automobile.</b>		
20c. TIME OF INJURY Month, Day, Year <b>11.00 p.m. 9-6- 1957</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) (County) (State) <b>Fairmount Hts, Pr. Geo. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-6-57</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-11-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry J. Washington &amp; Son</b> ADDRESS <b>467 N. St. N.W.</b>		24a. REC'D BY REGISTRAR <b>SEP 11 '57</b>	24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 11 1957

BUREAU V. S.

STATE AND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: *Charles* SEX: *Male* AGE: *61* RACE: *White*  
DATE OF BIRTH: *Jan. 6, 1903* PLACE OF BIRTH: *Illinois*  
RESIDENCE: *2101 N. 1st St., Chicago, Ill.*  
OCCUPATION: *Retired*  
CAUSE OF DEATH: *Myocardial infarction*  
MANNER OF DEATH: *Natural*  
SIGNATURE: *John T. Malone* DATE: *Sept. 10, 1957*

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9853**  
**CERTIFICATE OF DEATH**

09849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beaver Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Beaver Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Woods Jr.</u> Middle <u>Woods Jr.</u> Last		4. DATE OF DEATH <u>Sept 11</u> Month <u>11</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1888</u> 9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Indust.</u>	11. BIRTH PLACE (State or foreign country) <u>Virg, Va</u>
13. FATHER'S NAME <u>Albert Woods</u>		14. MOTHER'S MAIDEN NAME <u>Ada Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>233-072342</u> 17. INFORMANT <u>Ethel Hyton</u> Address <u>1419-52nd Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x</u> <u>Malnutrition &amp; Respiratory Paralysis</u> DUE TO (b) <u>PARALYSIS of Throat and Esophagus</u> DUE TO (c) <u>Cerebral Hemorrhage and Paraplegia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>1 wk.</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>53</u> to <u>Sept 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R Nelson</u> M.D.		ADDRESS (Street, city or town, state) <u>4112 GRANT ST. NE</u> DATE SIGNED <u>9/11/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert R NELSON</u>		<u>WASH. DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Washington &amp; Sons</u> ADDRESS <u>467 N St N.W.</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '57</u>	24b. REGISTRAR'S SIGNATURE <u>Robt. Couch</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. RACE White	
5. DATE OF BIRTH 12-1-22		6. PLACE OF BIRTH Memphis, Tenn.	
7. DATE OF DEATH 6-6-68		8. PLACE OF DEATH Memphis, Tenn.	
9. TIME OF DEATH 10:00 PM		10. CAUSE OF DEATH Suicide	
11. MANNER OF DEATH Suicide		12. MEDICAL HISTORY None	
13. OCCUPATION None		14. EDUCATION None	
15. RELIGION None		16. MARITAL STATUS Single	
17. SOCIAL SECURITY NUMBER None		18. SIGNATURE OF DECEASED None	
19. SIGNATURE OF WITNESS None		20. SIGNATURE OF PHYSICIAN None	
21. SIGNATURE OF CORONER None		22. SIGNATURE OF JURY None	
23. SIGNATURE OF JUDGE None		24. SIGNATURE OF CLERK None	
25. SIGNATURE OF REGISTRAR None		26. SIGNATURE OF ARCHIVIST None	
27. SIGNATURE OF ASSISTANT ARCHIVIST None		28. SIGNATURE OF ASSISTANT REGISTRAR None	
29. SIGNATURE OF ASSISTANT CLERK None		30. SIGNATURE OF ASSISTANT JURY None	
31. SIGNATURE OF ASSISTANT JUDGE None		32. SIGNATURE OF ASSISTANT CLERK None	
33. SIGNATURE OF ASSISTANT REGISTRAR None		34. SIGNATURE OF ASSISTANT ARCHIVIST None	
35. SIGNATURE OF ASSISTANT ASSISTANT ARCHIVIST None		36. SIGNATURE OF ASSISTANT ASSISTANT REGISTRAR None	
37. SIGNATURE OF ASSISTANT ASSISTANT CLERK None		38. SIGNATURE OF ASSISTANT ASSISTANT JURY None	
39. SIGNATURE OF ASSISTANT ASSISTANT JUDGE None		40. SIGNATURE OF ASSISTANT ASSISTANT CLERK None	
41. SIGNATURE OF ASSISTANT ASSISTANT REGISTRAR None		42. SIGNATURE OF ASSISTANT ASSISTANT ARCHIVIST None	
43. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None		44. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT REGISTRAR None	
45. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT CLERK None		46. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT JURY None	
47. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT JUDGE None		48. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT CLERK None	
49. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT REGISTRAR None		50. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None	
51. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None		52. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None	
53. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None		54. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT JURY None	
55. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT JUDGE None		56. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None	
57. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None		58. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None	
59. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None		60. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None	
61. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None		62. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JURY None	
63. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JUDGE None		64. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None	
65. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None		66. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None	
67. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None		68. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None	
69. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None		70. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JURY None	
71. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JUDGE None		72. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None	
73. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None		74. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None	
75. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None		76. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None	
77. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None		78. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JURY None	
79. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JUDGE None		80. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None	
81. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None		82. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None	
83. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None		84. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None	
85. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None		86. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JURY None	
87. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JUDGE None		88. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None	
89. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None		90. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None	
91. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None		92. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None	
93. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None		94. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JURY None	
95. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT JUDGE None		96. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT CLERK None	
97. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None		98. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None	
99. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ARCHIVIST None		100. SIGNATURE OF ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT ASSISTANT REGISTRAR None	

BUREAU V. 3

SEP 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9828

## CERTIFICATE OF DEATH

11096  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN 1b <b>X1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGE GEN. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>WRIGHT</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>20</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-20-57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA WRIGHT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>mother</b>		Address <b>asa bore</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Atelectasis</b> <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-20</b> , <b>1957</b> to <b>9-20</b> , <b>1957</b> , that I last saw the deceased alive on <b>9-20</b> , <b>1957</b> , and that death occurred at <b>11:40 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton St., Hyattsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>		DATE SIGNED <b>9/24/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>10/11/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Perkins, Jr.</b>		ADDRESS <b>Administrator</b>	
24a. REC'D BY REGISTRAR <b>Oct 16 57</b>		24b. REGISTRAR'S SIGNATURE <b>Oct 16 57</b>	

2077152 XVI

**BUREAU A. S.**

1957 16 OCT

RECEIVED

9854

CERTIFICATE OF DEATH

09850

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Texas b. COUNTY Val Verde			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB, Wash. 25, D.C.				c. LENGTH OF STAY IN 1b See Reverse			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Andrews AFB, Wash. 25, D.C.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Del Rio 80X-3			
				d. STREET ADDRESS 900 East 6th Street			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Melvin Wyman Jr.				4. DATE OF DEATH Month Day Year September 12 1957			
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 July 1917	
				9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot - U.S. Air Force				10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Frank M. Wyman Sr.				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT 4080th Air Base Group M/Sgt Paul Lock, Laughlin AFB, Texas	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries, multiple, extreme 860X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Aircraft Accident DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft Crash, Full Particulars Unknown			
20c. TIME OF INJURY Hour o. m. Month, Day, Year 2:25 AM Sept 12 1957				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Andrews AFB	
				20f. (City or town) Andrews AFB, Prince Georges, MD.		(County) (State)	
21. I certify that I attended the deceased from See Reverse, 19____, to____, 19____, that I last saw the deceased alive on____, 19____, and that death occurred at 2:25 a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1401st USAF Hospital 12 September 1957 Andrews Air Force Base WASHINGTON 25, D.C.							
ACTUAL SIGNATURE Reginald P. McManus M.D.				PHYSICIAN'S NAME (Type) REGINALD P. MCMANUS CAPT, USAF (MC)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamber Co.				24a. REC'D BY REGISTRAR SEP 16 1957		24b. REGISTRAR'S SIGNATURE O.W. Fisher	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A corrected Certificate of Death will be prepared and forwarded if additional information is received concerning items presently indicated as unknown.

CERTIFICATE

I, the undersigned, while in performance of duties as Medical Officer of the Day, for the 1401st USAF Hospital, do hereby certify that I was summoned to the scene of the aircraft accident and found subject officer dead upon my arrival thereat. It is my opinion that death occurred approximately 10 to 15 minutes prior to my arrival.

Item 1c: Unable to determine, aircraft had not landed.

*Reginald P. McManus*  
REGINALD P. MCMANUS  
CAPT, USAF (MC)  
Attending Physician

BUREAU V. 2

SEP 16 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09851

9757

## CERTIFICATE OF DEATH

Reg. Dist. No.

345

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Geo. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt Rainier, Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescent Home				d. STREET ADDRESS 4049-34th			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Eula Last Zook				4. DATE OF DEATH Month 9 Day 7 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1858		9. AGE (In years last birthday) 99 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Rufus Thurston Jones				14. MOTHER'S MAIDEN NAME Mary Barr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT George R. Lee Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease (c) Advanced Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20-30 years 40-50 yrs. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July, 1949, to Sept 7, 1957, that I last saw the deceased alive on Sept 6, 1957, and that death occurred at 6:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert B. Irey M.D. 7105 Riggs Rd. Hyattsville, Md. PHYSICIAN'S NAME (Type) Robert B. Irey							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gesche and Hyattsville Md				24a. REC'D BY REGISTRAR DATE SEP 11 1957		24b. REGISTRAR'S SIGNATURE James Lee	

